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Pharmacists to prescribe animal POMs?

Amended draft Charter sent to Privy Council

More details of contract cash given an airing

C&D Platinum Design Award winner profile



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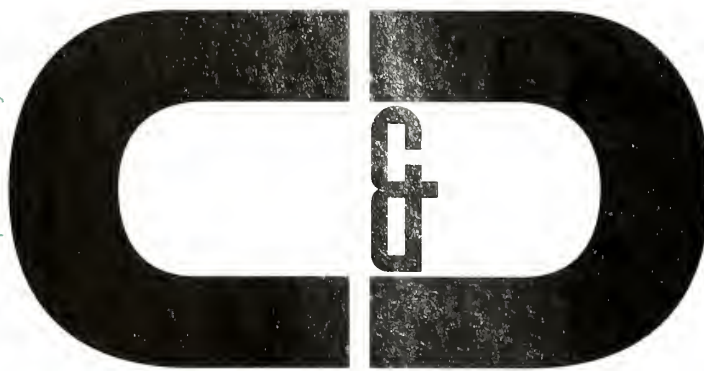
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A new category of prescription-only veterinary medicines has been proposed by the Veterinary Medicines Directorate. This POM-VPM category could be prescribed and supplied by a pharmacist or other registered qualified person

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Smith backs POM to P 14

England's chief pharmacist Jim Smith, left, is giving his full support to the first POM to P statin switch and he told diners at the College of Pharmacy Practice Schering Awards last week that he expects to see some significant reclassifications in the future

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Mary Allen guides pharmacists on what doses they might expect to see for opioids



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CEUTA

Pharmacists set for animal POMs

Know your opioid doses

When would you query a diamorphine dose?

The Shipman Report criticised a pharmacist for not challenging the doctor's prescriptions for diamorphine 30mg ampoules. In this week's *Pharmacy Update*, (see p23) hospice pharmacist Mary Allen outlines how opioids are used in practice and clarifies the doses pharmacists are most likely to encounter.

She advises that pharmacists confused about dose equivalences should contact their local hospice.

by **Adrienne de Mont**
ademont@cmpinformation.com

The Veterinary Medicines Directorate is proposing a category of prescription-only veterinary medicines that could be prescribed and supplied by a pharmacist or other registered qualified person (RQP).

This POM-VP category would include some current P and PMH products, and some medicated feeding stuffs that do not, at present, require a prescription. Other RQPs able to prescribe and supply these medicines would be registered veterinary surgeons or registered agricultural merchants.

Prior diagnosis would not be a pre-requisite, but the prescriber must be satisfied that the person administering the medicine is competent to do so and that use is

necessary for the routine control or treatment of endemic disease.

The other categories of medicines proposed in the VMD's 'informal concept paper' are:

- **POM-V** – medicines that may be prescribed by a veterinary surgeon following a diagnosis. Any registered vet or pharmacist could dispense the prescription. The category would include current POM and some P products for food-producing animals and pets, together with current medicated feeding stuffs. Current P products would be divided between the two POM categories, with general anaesthetics, heart and respiratory treatments and pain relief becoming POM-V, while vaccines and topical products will become POM-VP.

- **NPAM** (non food animal medicines) – medicines that a

registered qualified person (as above) may supply without a prescription to someone who is competent to administer them safely. This would include current PMH and non-prescription medicated feeding stuffs for pets including horses, which have been declared as not intended for human consumption.

- **General Sales List** – medicines that may be supplied by any retailer for use in non food-producing animals (or in an exemption list for food-producing animals, being drawn up by the European Commission).

The VMD is inviting comments, which will be considered before the draft Veterinary Medicines Regulations are sent out for consultation early in January 2005.

For more information:

www.vmd.gov.uk

Lloyds signs up for Skills

Lloydspharmacy has signed up over 500 of its pharmacists to the PSNC/C&D Skills for the Future training scheme to prepare them for the new pharmacy contract.

Director of training and development Steve Howard said the company was delighted with the response from its pharmacists who are willing to enrol on Skills for the Future. Lloydspharmacy has 1,364 pharmacies nationwide.

To date, around 2,500 pharmacists have signed up to the training package, which was developed by the University of Medway and supported by GSK. Two PCTs have agreed to fund their contractors for the training.

St Helens PCT in Merseyside has asked its 40 pharmacy contractors to register for Skills for the Future. It joins Southport and Formby PCT in encouraging its pharmacy contractors to follow the scheme.

For more information:

www.dotpharmacy.com/skills.html

Pharmacy contract details on funding come to light

Details of funding for the new pharmacy contract and how the money could be distributed have emerged.

The £1.766 billion funding for the contract in England is composed of the existing global sum, purchase profits and new monies, Jeanette Howe, head of Pharmacy and Prescriptions at the Department of Health, said at an NHS Confederation conference last Wednesday (see p20). She said the joint cost inquiry carried out by the DoH and PSNC had shown that the cost of the existing pharmacy service was not being met by the current global sum.

Furthermore, the £300 million the Government had saved by twice reducing the prices of four generics (lisinopril, doxazosin, simvastatin and omeprazole) would not be linked to the pharmacy contract, she said. This money will be returned to PCTs and as they wish.

Ms Howe also said the contract

would have a transition period, ie a start date and a date by which all pharmacies will be required to supply essential services. The contract would include measures to ensure pharmacies had the right level of staffing to deliver the services.

On training, she said the DoH was aware that it needed to engage workforce development confederations; the DoH will raise this with SHA leads, she said.

Numark and PSNC member Garry Myers outlined "ballpark" figures for the global sum for England at last weekend's Numark conference (see p 18). He said the NHS had set a baseline figure of about £800m for pharmacists' retained purchase profits on generic medicines, and that about £300m of this would be re-allocated to pharmacists' remuneration, leaving about £500m in purchase profits as an incentive to ensure generics' prices remain competitive.

He believed that around £100m would be ring-fenced for advanced services in the contract in each of the first two years. In year one, about 60 per cent will be allocated for ETP base connectivity, including hardware, and about 40 per cent for advanced services. In year two, about 20 per cent will be for ongoing IT maintenance and about 80 per cent for advanced services.

Mr Myers stressed these were general figures only and were subject to change. PSNC chief executive Sue Sharpe said the figures were "not accurate" and asked contractors to await "proper information, which PSNC hopes to publish in the near future, following its meeting this week".

The DoH said its ambition remained to agree a deal, which was fair for the NHS, for patients, taxpayers and pharmacy. "We aim to implement the new framework, once finalised and accepted, as soon as possible in early 2005."

Skills for the Future

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Skills for the Future

Module 7
Asthma

is included with this issue






Minimise drug stocks, says PSNC

Pharmacy contractors should try and minimise stocks of branded pharmaceutical medicines prior to any possible price reduction within the Pharmaceutical Price Regulation Scheme, PSNC is warning.

The current scheme, which allows manufacturers of proprietary drugs to set their prices to the NHS within agreed profit criteria, is due to expire on September 30 and, according to PSNC, when the new agreement is announced in the near future, it could include a percentage reduction in the prices of proprietary drugs reimbursed to pharmacy contractors.

"Pharmacy contractors need to be aware that an announcement is imminent, and subject to the overriding issue of service to their patients, try to minimise their NHS stock of proprietaries immediately prior to any price reduction," PSNC says.

The Dispensing Doctors' Association has similarly warned its members.

Council agrees final Charter

by Asha Fowells

afowells@cmpinformation.com

The Royal Pharmaceutical Society's Council has agreed to send a final draft of the new Charter to the Privy Council for consideration by the Queen.

Council members considered the outcome of the membership ballot, comments received during the ballot, and changes made to the draft by the Privy Council's advisers, before agreeing on the final Charter last Wednesday.

The advisers to the Privy Council's suggested changes are:

- clarifying the procedure for establishing new membership categories
- expressing the day the new Council come into office as a non-specific date
- allowing universities to choose how they appoint a Council member without Council involvement
- removing the need for Council to seek Special Resolution before changes in governance,

management or functions of the Society or Council. But the specific provision requiring approval by Special Resolution for any new membership categories, changes to the composition of Council, any Charter alteration, or surrender of the Charter or dissolution of the Society, was retained.

RPSGB president Nicholas Wood highlighted the Government view that corporate governance in regulatory bodies should be adaptable, and that accountability to members was secured by having an elected Council. Whereas using a particular approach, such as Special Resolutions, would risk Council becoming bound into it, losing its flexibility.

Graham Phillips said amending the article on resolutions changed the Charter to the extent that it no longer represented an effective compromise between the original draft and the version the membership had voted for. If Council was happy to be subject

to increased Privy Council scrutiny, it should accept that increased membership scrutiny went with it, he added.

Hassan Argomandkhah said this alteration was a movement towards a two-vote model, where only Council and the Privy Council had a say, and removed the safeguard of the membership's vote. Sultan Dajani said this was an important issue and should not be kept from the membership, and Martin Astbury asked that Privy Council be informed that this version would be rejected if put to a members' ballot.

Sixteen Council members voted for putting forward the amended Charter petition and Council members' comments to the Privy Council. Three (Mr Astbury, Mr Dajani and Mr Phillips) voted against and Mr Argomandkhah abstained.

The Privy Council will advise the Queen on the Charter next month, and, if approved, it will come into force on January 1.

Support for wider NPA membership

An IMS Intr@pharmQ survey has found pharmacists believe NPA membership should be extended to employee, locum, and primary care pharmacists, but not to internet pharmacies.

Other findings show that the RPSGB's handling of the draft new Charter has been generally fair, winning more support than PSNC's handling of the new pharmacy contract.

The online survey of community pharmacists which ran through August had 140 responses. Of these, 86.4 per cent of respondents supported employee pharmacist membership, 83.6 per cent supported locum membership, and 79.3 per cent were in favour of primary care pharmacist membership.

Only 21.4 per cent thought internet pharmacies should be allowed to be members.

More details appear on page 16.

Pfizer stands by quota policy for drug supply

by Gary Paraguri

gparaguri@cmpinformation.com

Pfizer is to continue using a quota system to control the supply of its pharmaceutical products despite industry concerns that this could lead to drug shortages.

Pfizer group commercial manager David Robertson said the new policy, which will supply each wholesaler depot with a set quota of Pfizer's products, would ensure the availability of sufficient supplies of the company's medicines to meet patients' needs. In addition, Pfizer could operate its supply system "more efficiently and effectively" and would reduce the risk of shortages, he said.

But AAI group managing director Steve Dunn said Pfizer's actions could lead to shortages, as wholesalers had been given no indication of how quotas would be established (*C&D*, September 11, p9).

Mr Dunn highlighted four scenarios where Pfizer's quota policy could lead to drug shortages. These were: where a shortage of generic alternatives led to regional demand variances; where variances occurred because a particular depot was being re-fitted; increases in demand when a depot took on a large account such as a hospital; and variances because Pfizer was unable to supply products.

In each case there may be

insufficient medicines in the system to meet extra demand because each depot would be restricted to a quota supply.

But Mr Robertson said Pfizer's policy was intended to be flexible enough to cope with changes in the UK market and to maintain its service levels. Mr Dunn added that Pfizer's actions meant it was transferring the risk of supplying medicines away from pharmacists and wholesalers and onto itself.

The DoH said Pfizer had assured it that there would be sufficient supplies to meet pharmacists' and patients' needs. But it added that it would monitor the situation and "respond accordingly" if there were supply problems.



...the... (text is partially obscured and blurry in the original image)

OPINIONS

OFT reforms will not be 'death knell'

Health minister Rosie Winterton has dismissed concerns that the proposed changes to pharmacy control of entry regulations will lead to the "death knell" of local pharmacies.

"I know some remain anxious about OFT, but I believe the reforms will bring benefits to patients," Ms Winterton said at an NHS Confederation conference last Wednesday (see p20).

"I do not share the view that this signals the death knell of the local pharmacy. Rather, it emphasises our belief that Government does not see pharmacies as just another retail outlet but an integral part of the NHS," the minister added.

Ms Winterton said since she had been at the DoH the Government had re-affirmed its commitment to pharmacy in the *Vision* document, in the *NHS Improvement Plan* and in *Building on the Best*. The minister highlighted the 200 pharmacists registered as supplementary prescribers and the use of the NHS logo in community pharmacy as further evidence of the Government's commitment.

PRACTICE

Guide to finding time

GlaxoSmithKline has launched guidance to help pharmacists make time for new contract activities.

Do you have time for the new contract? considers everyday pharmacy activities and suggests changes, ranging from staff training and delegation to building a case for new services funded by the primary care trust. The author is Dr Hooman Ghalamkari, a practising pharmacist in Worcester and director of MORPh consultancy.

A National Pharmaceutical Association survey found that 43 per cent of pharmacist respondents cited lack of time as their greatest frustration.

The resource will be available to pharmacies from their +Plus account manager from October.

For more information:

+Plus Customer Contact Centre
Tel: 0800 221441

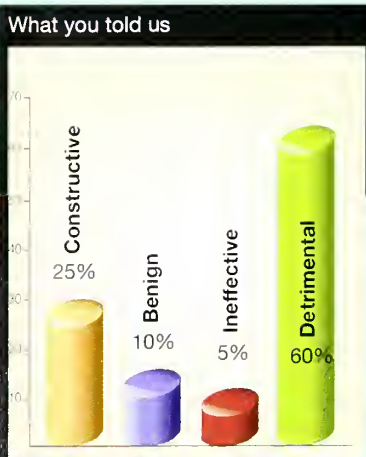
Questiontime

Last week we asked what you felt the pharmaceutical industry's influence on health policy was. You replied (see right):

This week's question: The VMD has proposed that pharmacists should be allowed to prescribe some veterinary POMs. What impact could this have?

- Will encourage all pharmacies to get involved in supplying veterinary products
- Only rural pharmacies will benefit
- Will make little difference to the pharmacy market

You can record your vote on our website: www.dotpharmacy.com. You have until noon on September 28 to cast your vote. We will publish the results in *C&D*, October 2.



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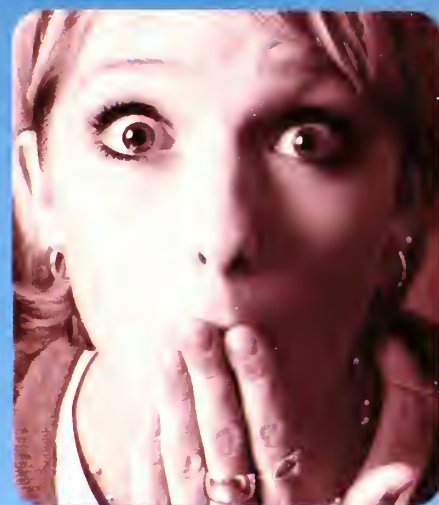
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1	2	3	4		5	6
7	8	9	10		11	12
					13	
	14	15	16	17	18	20
						21
22			23	24	25	26
						27
						28

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Guide will help pharmacists who want to form 'one-stop' consortium

The NPA has published a guide to help independent pharmacies that would like a stake in one-stop primary care health centres.

The NPA's NHS Service Development department, in collaboration with its business section, has produced the 40-page document *Consortium Pharmacies - A Guide for NPI Members in England*. It explains the pros and cons of local pharmacies clubbing together to bid for the pharmacy element in a one-stop centre; how to go about forming a consortium; and how it might be run.

Karen Homan, head of the NPA's NHS Service

Development, says: "We are getting a lot of members saying, 'A one-stop centre could threaten my business: what can I do about it?'"

Among the subjects discussed in the document are:

- what pharmacy consortia are
- company formation
- holding meetings
- premises costs
- business aspects of running a consortium pharmacy.

In addition, the guide includes models for consortium articles of association and a memorandum of association.

- Another way independents could access advice on business

development and consortium arrangements is being proposed by Yorkshire-based Living Care Group.

The Group, which owns a chain of 14 community pharmacies in Halifax, Wakefield and Leeds, is headed by pharmacist and entrepreneur David Lestner. "We are trying to help independent pharmacies remain independent," he said.

Living Care Independent Pharmacy Services co-develops health centres with Lunn Healthcare Facilities. "It is hard for independents to compete against the big boys," explained

Mr Lestner. "If we are developing a medical centre, we invite the local independents to participate. If a number of them are interested in the proposition we would get them round a table and help them work out a consortium arrangement."

The cost of rent would probably be higher than for a local retail unit, he agrees, but would reflect the higher standard of accommodation being offered, and would be 'open to negotiation'.

For more information:
www.npanet.co.uk
www.livingcare.co.uk

Better deal from club

The CAMRx Pharmacy Development Group is launching the CAMRxTRA club at the end of the month. It will offer members PMR systems, UniChem's 'Portfolio' scheme and Campdale Ltd short-liner generics and parallel imports.

Convention

AAH Pharmaceuticals has announced that its 2005 customer convention will be held in Sintra, Portugal, from May 17-22 at the five star Ritz Carlton Penha Longa Hotel & Golf Resort.

Phoenix consults its customers

Phoenix says that it is addressing concerns expressed by its customers responding to its biennial questionnaire on a depot by depot basis.

While customers complimented the friendliness and performance of the Phoenix sales team, the accuracy of order picking, product availability, expired or damaged goods and delivery times were cited as issues in some areas.

Phoenix chief executive David R Cole said: "Everyone at Phoenix is aware that there is always room for improvement but we do strive to do our best for our customers at all times."

He added: "The percentage of items sent back as 'ordered in error' is of some concern to us and particularly time consuming."



As a result of the survey, the company says that certain disciplines are being introduced

into the customer services department to ensure increased efficiencies when dealing with customer queries and liaising with operations and the transport managers to ensure that all van runs keep to time.

The customer questionnaire asked pharmacists to rate the performance of Phoenix against local and national competitors. Of the

2,426 copies sent out 918 were completed and returned, a 38 per cent response rate.

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Conference time for pharmacists

Community pharmacists hope to be able to raise pharmacy issues at fringe meetings taking place at the Labour Party Conference.

Four Brighton pharmacists have been primed to contribute to debates taking place in the 'Health Hotel', which are likely to be attended by ministers, senior figures from all the health professions and journalists, as well as party members and the public.

The move is being tried as an alternative to having a stand for organisations representing pharmacy (including the RPSGB, NPA, PSNC and the CCA) at the Labour Conference exhibition, as has happened in previous years.

The hope is that any points made will carry more impact as they will come from local pharmacists rather than being the 'corporate' message

from pharmacy politicians.

Pharmacy interests were represented at this week's Liberal Democrat Conference. A fringe meeting on 'bringing healthcare closer to home' was sponsored by the pharmacy organisations, and was organised by the Centre for Reform, "an independent, free-thinking forum for new ideas and progressive debate".

Jonathan Ellis of Help the Aged spoke of the role of pharmacists in elderly care while Liberal Democrat health spokesman Paul Burstow mentioned the role of pharmacists in screening.

PSNC public affairs officer Melanie Smaus said that awareness of pharmacy was increasing at the political conferences. "Pharmacy is seen as an integral part of the [healthcare] team," she said.



Pharmacists at the Labour Party Conference. The RPSGB, NPA, PSNC and the CCA have been primed to contribute to debates taking place in the 'Health Hotel', which are likely to be attended by ministers, senior figures from all the health professions and journalists, as well as party members and the public.

NHS Direct translator

The interpretation service that is being offered by NHS Direct, the 24 hour telephone health advice and information service, should be available to pharmacists who have language difficulties

communicating with customers about their prescriptions.

According to NHS Direct, pharmacists should check whether

their local PCT has bought into the service. Patients who do not speak English could call NHS Direct and will be linked to an interpreter who will liaise between the patient and NHS Direct staff.

The contract for the interpretation service was awarded to Bowne Global Solutions earlier this month.

Lambeth OUTLOOK

Signs of improvement?

As the conference season sets in, Beverley Parkin, RPSGB director of public affairs, anticipates the discussion on the *NHS Plan*

At last year's Labour Party Conference, health minister John Hutton said something very revealing about the views of senior Labour politicians about the NHS. He directly addressed the values, principles and the culture of delivery within the NHS. He pointed out that Nye Bevan, the founding father of the NHS (in the political sense at least), had always said that methods of service delivery in the health sector would change and should change as the service grew and evolved.

Now I suspect Nye would have taken issue with some aspects of Hutton's vision. It would certainly be interesting to hear what he thought of Sir Nigel Crisp's presentation of the *NHS Improvement Plan*. The Plan was initially published in July but Sir Nigel recently presented its provisions to staff, setting out a framework for the delivery of Labour's thinking. Whatever one thinks of this Government, the *Improvement Plan* highlights very clearly the direction of travel and paints Sir Nigel in the role of quiet revolutionary, grinding away behind the scenes, producing results.

The Plan pledges allegiance to the founding principles of the NHS but points out that they are to be "given modern meaning and relevance in the context of people's increasing ambitions and expectations of their public services". It also draws together the Department of Health's achievements since Labour came to power: the NHS budget increased from £33bn to £67bn today; health spending per head of population doubled; 19,400 more doctors, 67,500 more nurses, 26,000 more therapy, scientific and technical staff; 24 new hospitals with 57 more on the way, as well as 280 new one-stop treatment centres.

There is clear commitment to improve and expand the incentive mechanisms to reward and drive clinicians and other staff, which



hints at an approach that begins to emulate a private sector ethos in a public sector setting. The nebulous concept of choice remains central to the vision but so too do practical steps like the freeing up of control of 80 per cent of the NHS budget to PCTs and the implementation of independent inspection regimes.

There are huge changes too in the whole approach of the NHS to patients. The *Improvement Plan* seeks to actively encourage people to lead healthier lives and in so doing reduce the burden on healthcare professionals. So the aim is to see health inequality reduced and there are mortality targets for 2010 to reduce death rates from CHD and strokes in those under 75 by at least 40 per cent. This approach is likely to herald a sea-change in the way that patients are advised by front line staff, like pharmacists, who are likely to find themselves in a central delivery role. The imminent publication of a public health-related White Paper will provide an opportunity for pharmacy to engage in this debate.

What is very clear in the *NHS Improvement Plan* is that 'local' is the new 'central' with the DoH charged with forging new relationships with local authorities, PCTs and private sector bodies. The profession too will play its part in the development of these new relationships.

With Sir Nigel speaking at the British Pharmaceutical Conference on September 27, the profession will be able to hear first hand his plans for the NHS.

[illegible]

Smith backs POM to P programme

England's chief pharmacist has given strong support to the first POM to P statin switch, and says more significant reclassifications are on the way.

"I have no doubt about the balance of risks and benefits in taking simvastatin over the counter. I expect to see some significant reclassifications in the

future," he told guests, including the three chief pharmacists from the other home nations, at the College of Pharmacy Practice Schering Award dinner in London last Thursday.

But he warned that pharmacists had to be up to the task of handling new OTC medicines.

"We have to make sure

standards of procedure are the best. I am dreading seeing a *Which?* type article in a year's time about how we do or do not manage OTC situations."

Dr Smith also voiced concerns over the slow start to pharmacist prescribing. "We are playing catch-up. We need to get more pharmacists into training

programmes: there have been surplus places on some. We also need to think carefully about what independent pharmacist prescribing might look like. This is not a devolved issue so the four home nations need to work together. The health minister, advised by the CSM, will make the decisions."

Dr Smith, visiting member of the Royal College of Physicians, also praised the work of the College of Pharmacy Practice, which has been instrumental in the development of the POM to P programme. He is currently president of the College, which is the professional body for pharmacists in the UK. Dr Smith also praised the work of the College of Pharmacy Practice, which has been instrumental in the development of the POM to P programme. He is currently president of the College, which is the professional body for pharmacists in the UK.



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Competition and choice may mean total deregulation, says lawyer

Introducing a 'competition and choice' criteria to the 'necessary or desirable' test for new pharmacy contracts could constitute deregulation by the "back door", a pharmacy law expert has said.

David Reissner of law firm Charles Russell said the new criteria (*C&D*, Aug 21, p4) could mean all applications would have

to be granted, as every new pharmacy would increase competition and choice. But it would be difficult to know exactly what would happen until the DoH published draft regulations, he added.

PSNC regulation head Stephen Lutener said that, because the competition and choice criteria

will be introduced through secondary legislation, it showed the DoH was not intending to weaken the 'necessary or desirable' test. But he added: "PSNC will certainly be keeping an eye on it because we don't want to undermine the network of local pharmacies."

NPA chief executive John

D'Arey agreed with Mr Reissner's view: "It is vital that PCTs are given clear guidance to implement this new rule. Given that PCTs have overall responsibility for the provision of local pharmacy services, it should be they, rather than a market free-for-all, who are in control of the decision-making process."

Personal control consultation due soon

A consultation on changes to the pharmacy workforce and personal control is to be launched next month, the RPSGB has said.

Fitness to practise and legal affairs director Mandie Lavin said a joint consultation from the chief pharmaceutical officers was due to be issued in the next fortnight.

A DoH spokesman said: "Our proposal is that whilst a

pharmacist remains responsible overall for ensuring that appropriate procedures and checks for the supply of medicines are followed, such technicians need not be supervised personally at all times by the pharmacist. We promised to consult on the details and plan to take this consultation forward later in 2004."

The consultation will last three months and lead to primary legislation changes. Ms Lavin said this was a good time to debate such matters in light of the changing role of the pharmacist and pharmacy staff, and because the Shipman Inquiry was likely to make changes to regulations including the *Medicines Act* and *Misuse of Drugs Act*.

EHC advice

The Royal Pharmaceutical Society has published updated practice guidance on the supply of emergency hormonal contraception as a pharmacy medicine.

The guidance incorporates revised dosage instructions and is available on the RPSGB's website at www.rpsgb.org/practice or by telephoning 020 7572 2409.

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Last week we asked what you felt the pharmaceutical industry's influence on health policy was

Comment

from the Editor

"Sometimes good, sometimes bad. They can be a bit pushy in getting patents for new drugs but on the other hand they put a lot of money into developing new drugs"

Anonymous,
Eastbourne

"Constructive, because it's good for the NHS to keep in touch with both sides – pharmacists and the industry"

Rocia Barrera,
Southampton

"Benign. They've got their own agenda and will do what's good for them"

Akesh Lad, Leicester

The saga of the RPSGB's Charter looks as though it is drawing to an end. Council has approved a draft and submitted it to the Privy Council, and Her Majesty willing, it is likely to come into effect at the start of 2005 (p7).

But the draft that has been submitted is not actually the one that pharmacists voted on this summer – the Privy Council advisors, despite having been consulted in the drafting of the June version, have since said that it would be better if a Special Resolution wasn't needed to approve every last decision of the Society's Council.

Sounds reasonable, doesn't it? But for some this is contrary to what pharmacy's civil war was waged for: to ensure that there were adequate checks and balances within the profession's governance to ensure that pharmacists are members of the Society and not just 'registrants'.

Time will tell if these fears are founded, but with an entirely new Council to be elected, look out for much more heated debate.

Meanwhile, the pharmacy contract continues apace. While the finer monetary details are still to be unveiled, a few points should be noted. The DoH has admitted that existing pharmacy services were not being met by the global sum (p6). There will be a transition period as the new contract comes in, but then, any pharmacy not providing essential services could quickly lose its right to dispense. And there will also be measures to make sure staffing requirements are met.

It is also apparent that contractors should already be considering whether they will look to service provision for their income in future or whether their bedrock will be a progressively less well paid dispensing service.

Contractors should be considering whether to look to service provision for their income in future

Your views

Online views of ruling bodies

The latest Intr@pharmQ online survey of community pharmacists operated by IMS asked for views about the pharmacy bodies.

How do you rate the RPSGB's handling of the new draft Charter?

(140 responses)

Very good	1.4 %
Good	22.1 %
Fair	47.2 %
Poor	19.3 %
Terrible	10.0 %

Out of 18 pharmacists on the new RPSGB Council, three will be elected to represent England, Scotland and Wales, and one will be appointed to represent academia. Do you think there should be further sectional

representation (for example hospital/industry/primary care) on the Council?

(140 responses)

Yes	60 %
No	22 %
Not sure	18 %

How do you rate your PSNC in dealing with the Government?

(124 responses)

Very good	4.8 %
Good	18.5 %
Fair	33.1 %
Poor	32.3 %
Terrible	11.3 %

Do you think that the main pharmacy bodies (eg RPSGB, PSNI, NPA, UCA, SPF, PSNC, SPGC, PCC, GHP) should work together more closely?

(140 responses)

Yes – as one body representing all pharmacy for developing the profession and negotiating with government 35 %

Yes – to speak with one voice in public or to the government but to otherwise carry on individual roles 38.6 %

Yes – the Societies should remain distinct but the organisations like NPA and PSNC should merge 8.6 %

Yes – but with better employee/locum representation 7.9 %

No – satisfied with the way they operate now 5.0 %

No – there is too much overlap so each organisation should strive to strengthen their own individual identities 5.0 %

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TOPICAL REFLECTIONS

Selling my own brand

I am fascinated by Pharmacy2U's latest expansion scheme (*C&D*, September 18, p8). It sounds like the company wants to use local pharmacies' good names to encourage customers to use its site. It seems like a good idea and a scheme that operates successfully in other spheres of business: a relatively unknown service provider works with a recognised brand name to deliver a service to customers who want to use a company they trust.

I am flattered that Pharmacy2U believes the name of my pharmacy will attract significant numbers of additional customers. But either I'm lacking vision or underestimating the power of my brand.

Most of my customers are elderly and like coming to the pharmacy for the outing, the company and the personal service. The housebound can have their prescriptions (and even sometimes their shopping) delivered simply by phoning.

Support your drugs industry

It is right that the Health Select Committee is investigating the influence of the drugs industry on the Government (*C&D*, September 18, p4). As one of the UK's most successful industries it wields significant power that must be kept in check. Drugs and health are emotive issues and any suspicion of wrongdoing in these areas will always grab headlines.

I am always sad to see the industry portrayed by the media as the 'baddie' who profits from people's ill health, however. Very rarely do I read a 'good news' story about how many lives have been saved as a result of drug innovation. Of course these companies make profits, but it is only as a result of this profit that they can discover new drugs, employ huge numbers of people, and make a significant contribution to the UK economy.

It seems odd to me that the pharmaceutical industry, whose ultimate aim is to help the sick, gets more bad coverage than, for example, the arms industry. The UK weapons industry is highly successful, yet it aims simply to kill and maim.

My personal opinion is that there is far more corruption in this industry than most others. And what about other successful industries such as the major supermarket chains or our Fleet Street newspapers? These are powerful groups that wield their power in unwholesome ways but are not so often criticised.

The pharmaceutical industry seems a victim of that British condition that is anti-success. We value the brave loser or the person in second place with the sad story. But a British winner is simply there to be knocked off their pedestal. I think the delight in the demise of Paula Radcliffe or the England football team is an unsavoury national trait.

More leading medicines have been discovered in the UK than anywhere else in the world apart from the USA.

Surely that is something to be proud of? I only hope the industry comes out of this investigation with the flying colours that recently eluded Paula Radcliffe and our national football team.

Less than half the drugs prescribed by GPs are actually taken by patients in the manner intended. More to the point, a large proportion of drugs simply aren't taken at all.

It can be disconcerting for a GP totally convinced that Mr Jones is looking so fit and well thanks to the regular doses of medicine only to have a waterfall of dated, unopened bottles cascade out of the bathroom cabinet.

Poor compliance? Obviously – and many GPs feel threatened, let down even, by such admissions. Yet we are perfectly happy for most diabetic patients to adjust their dose of insulin, and anti-blood coagulation is increasingly monitored and dose adjusted by patients themselves. In Germany it is the norm not the exception.

Asthma may be the next 'patient at the com' condition. The SUND study showed a clear improvement in the patients' perception of control over their symptoms when they were allowed to adjust their dosage of inhaled medication.

There is a movement out there for people to take more responsibility for their own health

All of this raises questions over the value of fixed dosage in other areas and the way medicines, particularly antibiotics, are prescribed. For instance, why 250mg? Why not 223.57mg? Someone weighing 18 stone probably needs more medication than someone half the weight.

And why five days? Chlamydia is treated with a single dose. Analgesics are prescribed as "Two tablets every six hours." There is a movement out there, being driven more by patients than doctors and supported by government with initiatives such as 'the expert patient' for people to take more responsibility for their own health and this includes self-medication.

Dr Ian Banks is a GP practising in Northern Ireland



NumarkConference



Lord Foster: "A period of unprecedented change"



Numark chairman Lord Fowler (above) warned members that although the group was doing well since becoming publicly traded, there had "never been a time when membership has been more crucial".

"We're moving through a period of unprecedented change. It's very important independent pharmacy has a voice... [it] should have a say in defining its role," he said before reiterating his concerns that control of entry is not over as an issue.

Simon Colebeck, managing director of Numark Trading Ltd (NTL), warned delegates that the pharmacy market was growing but independent pharmacy's share continued to decrease.



Simon Colebeck warned that the independent share is decreasing

Market dominator Boots had recovered from its temporary poor spell and was clawing back its market share, as were supermarkets, he said. Conversely, the category of 'other chemists', into which Numark is assigned, was losing its share of the pharmacy trade, falling from 6.9 to 5.2 per cent. More positively, NTL's sales grew by 10 per cent year-on-year to the end of July to around £26 million. Sources of growth were new business (around £750,000), but this was overshadowed by £24,000 of organic growth.

Mimi Lau, Numark's professional services controller,

Numark gears up for new contract

Fiona Salvage and Gary Paragpuri report from last weekend's Numark Autumn Conference in Longleat where the hot topic was the new pharmacy contract



Mimi Lau - contract tips

said the company's Extend programme, which was launched last month, will be rolled out in three phases: an audit to determine how prepared members are for the new pharmacy contract; feedback to members to see how they match up to the objectives of their primary care organisations; and the development of specific initiatives by Numark for members in areas such as cardiovascular, weight management and osteoporosis. Ms Lau urged members to return their audit forms before phase two was rolled out in late October.

She also highlighted ways in which members could prepare for the new contract. Contractors should: review the education and

training requirement of their staff; review their premises with regard to consultation areas and explore the use of branding with the NHS logo; and develop relationships with PCTs.

Chief executive David Wood backed the call for members to invest in premises and training. The new contract could be the last opportunity for pharmacy and, if pharmacists did not grasp it, others could step in, he said.

Marketing director Andrew Sollitt revealed details of the Numark TV advert to be aired from late October. The 30-second and 10-second adverts will carry the strapline: "Something to feel good about" to tie-in with point of sale material and prescription bags.

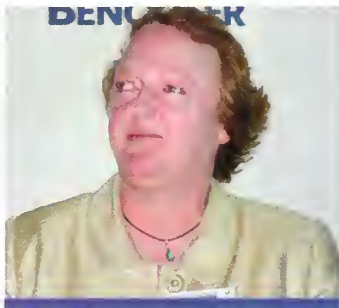
Category development manager Emma Betts highlighted the company's geo-demographic profiling service, which determined the local population around pharmacies, allowing pharmacists to target products and services to customers more effectively.

The data had revealed regional trends in brand preference, with some definite North-South divides. Ms Betts said the current "one size fits all approach isn't appropriate". A geo-demographic approach increased sales, profit and longevity for OTC.

Musa Dhalla, director of Webstar Health, said because contractors will derive a greater share of their gross profit from NHS remuneration as opposed to from purchasing profits under the new contract, they must be prepared to refocus how their business is positioned. The new contract has three main themes – dispensing, public health and chronic disease management – and pharmacists will have to decide not which one of these services they will provide, but in what proportion they will provide all three, Mr Dhalla said.

High street pharmacies with no ties to a GP surgery may have a public health focus, while pharmacies with close links to health centres may choose to focus on chronic disease management. Those who chase prescription volume will need to become low cost providers, but Mr Dhalla warned that these were "not mutually exclusive activities".

Keele University education director Alison Blenkinsopp highlighted chronic disease management opportunities for pharmacists in the new GMS contract, which contains 42 points specific to medicines management (worth about £4,150 per average GP practice in 2004 and £5,040 in 2005).



Alison Blenkinsopp - opportunities in a new GMS for pharmacy

Pharmacists could offer practice-based clinics with or without supplementary prescribing, medicines use reviews, monitoring and support for patients with hypertension, diabetes and asthma, surveillance and risk reduction by addressing poly pharmacy, and providing support for self management, Professor Blenkinsopp said.

Independent consultant John Blenkinsopp offered hints on future POM to P switches. Medicines to tackle chronic migraine, CV disease protection, GI conditions, asthma, skin conditions, pain management and eye infections could all be switched soon.



David Wood - new contract could be last opportunity

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Reference:

1 Strecher V *et al* Poster presented at the 12th World Conference on Tobacco or Health, Helsinki, 3-8 August, 2003.

The Heineken effect

As the new pharmacy contract could be in place in as little as three months' time, PCTs are desperate for details. At last week's NHS Confederation conference, **Gary Paraguri** heard how pharmacy was promoted to its future paymasters

Earlier this year, the NHS Confederation surveyed primary care trusts to see how they were gearing up for the new pharmacy contract.

Encouragingly, 85 per cent had already identified a contract implementation lead, with about three quarters using the same person who did the groundwork for the new GMS contract. But the survey found PCTs lacked details of contract timescales and finances and that failure to provide these would impose extreme pressures on PCTs, as happened with the GMS contract.

So last Wednesday, nearly 200 primary care representatives attended a London briefing to hear health minister Rosie Winterton, Greater Peterborough Primary Care Partnership chief executive and pharmacy contract negotiator Chris Town, PSNC NHS Services head Alastair Buxton, and DoH Pharmacy and Prescriptions head Jeanette Howe outline what pharmacists will do under their new contract and how this will benefit PCTs.

Ms Winterton said there were now "dynamic opportunities" for the NHS to forge new working relationships with community pharmacy. "Not grasping these opportunities could set back shared health ambitions for years," she warned. Further, the Government will invest £90 billion per year in the NHS by 2007, up from £34bn in 1997 and, in return, patients must be offered a radically more modern service, she said.

"If we stick to old-fashioned



Jeanette Howe (in red) fields questions on the new pharmacy contract, from a delegate at an NHS Confederation conference. She is flanked by Chris Town on her right and Alastair Buxton and Sue Sharpe on her left

notions that professionals only work in pre-determined silos then we will fail in our ambitions. Traditionally doctors diagnosed and prescribed, pharmacists dispensed and nurses administered medicines. All that is changing now with extended responsibilities for prescribing, including by pharmacists. If we can revolutionise the way in which services are offered, we can revolutionise patient perceptions and experience of the NHS."

Community pharmacy has a history of breaking new ground, Ms Winterton said, and she urged PCTs to think about how they could better utilise pharmacists to help with long-term conditions, such as diabetes or mental health problems. She also highlighted the trust that patients had in pharmacists. "That came over

clearly from the Big Conversations I had in the summer where members of the public suggested that there is a greater role for pharmacists to play. Pharmacies are essential, easily accessible, reliable and often the first port of call for patients needing advice and help."

Echoing the minister's comments, Chris Town said the new pharmacy contract is key to modernising primary care services. The existing pharmacy contract doesn't encourage PCTs to engage with pharmacists whereas the new framework will focus on delivering high quality services and ensure that pharmacy is more closely aligned to the PCT's role in developing local service provision. PCTs should think about their complex health provision problems and

how they can use pharmacists' clinical skills to address these.

Pharmacy repeat dispensing and ETP will improve patient choice and convenience, while minor ailment schemes will help PCTs meet 24/48-hour access targets, Mr Town highlighted. Further, pharmacy-led clinics in areas such as diabetes will reduce the demand for GP services and pharmacy-based minor ailments schemes have shown they can reduce GPs' workload without any rise in costs. But pharmacists also offer value for money in addition to their clinical skills: every £1 invested in a medication review produced savings of £2, while pharmacists who provided repeat dispensing saved between £2.60 and £10 per patient per month, he said.

However, Mr Town expressed concern over what he called the 'Heineken Effect': preaching to the 'converted' about the value of the pharmacy contract was relatively easy but reaching all PCTs to ensure they worked collectively was an entirely different matter, he suggested.

He highlighted some of the initiatives that his own PCT was planning in preparation for the pharmacy contract. These included expanding existing pharmacy schemes such as minor ailments, looking to see if areas of greatest need had access to pharmaceutical services, setting up a register of all pharmacists including locums, ensuring pharmacy service provision was incorporated in the local delivery plan, and identifying learning needs.

How did Jenny Parkin equip her pharmacy for testing times ahead?

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In light of comments made by Dame Janet Smith in the Shipman Inquiry, *Mary Allen* FRPharmS guides pharmacists on what doses they might expect to see for opioids. (This replaces the scheduled article on Vitamin D, which will be published at a later date)

Opioid dosage



THE COLLEGE OF PHARMACY PRACTICE

This course (module 1316), in association with multiple choice questions being published in *C&D* October 2, provides one hour's continuing education

Some pharmacists thought the recent Shipman Report was rather hard on the pharmacist involved in supplying, without challenge, the diamorphine Dr Shipman used to kill his patients. Many pharmacists will feel sympathetic and wonder whether they, in the same circumstances, would have queried the doses prescribed.

Everything is easier with hindsight, but how can pharmacists know what appropriate doses are for drugs like morphine and diamorphine? The simple answer is that they can't always know, unless they know more about the patient, and perhaps a bit more about standard patterns of prescribing opioids.

Opioids are used mainly in three circumstances in primary care:

1. For myocardial infarction (or other severe acute pain)
Diamorphine is used to manage the pain (and anxiety) of myocardial infarction. The *British National Formulary* gives doses as 5mg diamorphine (by slow intravenous injection –

1mg/minute), followed by a further 2.5–5mg if necessary. The dose is halved for elderly or frail patients. Rarely, a GP may use diamorphine or morphine for severe pain caused by a fracture, or renal colic, although diclofenac injection is usually thought to be better.

For acute pain, the drug would be administered as a stock item from the GP's bag. GPs who carry diamorphine ampoules in their bags (not all do) will have purchased the ampoules using a signed order. There would be no



Pharmacists may not be able to stop another Shipman, but knowing about the patient and a bit more about the standard opioid prescribing patterns may, at least, support better palliative care

time for a doctor to write an FP10 for the individual suffering an MI. So it's unlikely that community pharmacists would be presented with a prescription for diamorphine or morphine for use in these circumstances.

2. For breathlessness (dyspnoea)

Sometimes, low dose opioids (usually oral morphine sulphate solution 10mg/5ml, but occasionally diamorphine injection 5mg at a dose of 2.5–5mg) is used to relieve breathlessness (dyspnoea) in

palliative cancer care and in patients with motor neurone disease.

3. For severe chronic pain (cancer pain)

The most frequent use for strong opioids in primary care is to manage severe chronic pain, usually cancer pain.

Usually patients prescribed strong opioids have already been taking other analgesics so, unless patients or their families or their nurses use a variety of pharmacies, there is often a medication history to work with

when considering whether a dose is appropriate or not.

The simple rule for treating chronic cancer pain is "by mouth, by the clock and by the ladder".

By mouth: all patients should take analgesic drugs by mouth unless they cannot, for example, because they have trouble swallowing, or because of protracted vomiting, or they are

Continued on page 24 ►

sleeping a lot or semi-comatose.

● **By the clock:** in chronic pain, analgesia should be taken at regular intervals, not when pain comes back. The aim is to titrate a dose that controls the pain and give this at regular intervals. "PRN" dosing usually results in poorly controlled pain.

● **By the ladder:** refers to the World Health Organization (WHO) analgesic ladder, which involves a stepwise approach to chronic cancer pain control. Simple analgesics like paracetamol or ibuprofen are often adequate (step one). Sometimes the addition of an adjuvant analgesic provides good pain relief, particularly for neuropathic pain, which often responds well to tricyclic antidepressants such as low dose amitriptyline or anticonvulsants such as carbamazepine or gabapentin. Bone pain responds well to NSAIDs.

Step two of the WHO ladder includes the weaker opioids including codeine or dihydrocodeine, with or without paracetamol/NSAIDs/antidepressants/anticonvulsants.

Step three: strong opioids Once step two analgesics fail to control chronic cancer pain adequately, patients move on to step three. Their needs are likely to be 40-60mg morphine (or equivalent) over 24 hours (unless they are deteriorating rapidly or experiencing a pain crisis of some sort). Immediate release (IR) morphine can be given every four hours at doses of around 10mg, slowly increased until pain is controlled. Steady state is reached within 24 hours. Recording the total doses given over 24 hours allows requirements to be updated. Once stabilised on a 24-hour morphine dose, the daily total can be converted to a regular modified release (MR) preparation.

Strong opioids include not just morphine but oxycodone, fentanyl, hydromorphone and methadone. MR preparations include MST tablets, Zomorph capsules, Oxycontin tablets. IR preparations include Oramorph solution, Sevedol tablets, Oxynorm liquid and capsules.

The trick with analgesia in chronic pain is to find a dose of MR opioid that controls it in "normal" circumstances. This dose is, of course, optimised to provide the best analgesia with the fewest side effects.

● **Products are used:**

● **Titrate the dose needed to control pain before converting the**

World Health Organization ladder

Titrate to pain relief (no ceiling dose)

Step 3
Moderate to severe pain



Strong opioid eg morphine (oral), diamorphine (sc) +/- non-opioid analgesic +/- adjuvant analgesic

Step 2
Mild to moderate pain



Weak opioid eg codeine, dihydrocodeine, dextropropoxyphene +/- non-opioid analgesic +/- adjuvant analgesic

Step 1
Mild pain



Non-opioid eg paracetamol/NSAIDs +/- adjuvant analgesic (eg tricyclic antidepressant/anti-convulsant)

dose into MR products
● for breakthrough pain
● for incident pain.

Breakthrough pain

Breakthrough pain occurs when MR analgesic doses are insufficient to control symptoms and the patient experiences pain before the next 12-hourly tablet/capsule is due. A dose of IR morphine (such as Oramorph solution) equivalent to one sixth of the current 24-hour dose can be given. So for a patient on 30mg MR morphine twice daily, the breakthrough dose would be 10mg of IR morphine.

Patients (or carers) should note the number and frequency of breakthrough doses and, unless these are very occasional, the MR dose should be reviewed and increased to reflect the total 24-hour dose including IR doses. So someone taking 30mg MR morphine twice daily and regularly taking two or three 10mg doses of Oramorph will need a dose increase to 40-50mg MR morphine twice daily.

Doses of strong opioids can be safely increased in increments of 33-50 per cent every three days or so where necessary to control pain, without risking respiratory depression. Larger doses are often needed as patients deteriorate and some patients gradually build up over time to huge doses quite safely.

Incident pain

Incident pain, like breakthrough pain, can occur between doses of MR opioids, but is caused by factors other than sub-therapeutic MR analgesia, such as movement,

Give analgesics:

- by mouth (unless impossible)
- by the clock (at regular intervals)
- by the analgesic ladder

or a painful dressing change. Again, a dose of IR morphine equivalent to one sixth of the prescribed 24-hour dose of MR opioid can be given.

Unlike breakthrough doses, the number and frequency of incident pain doses should not be included in an analgesic review. This could result in rapid escalation of opioid doses and opioid toxicity. Instead, by recognising and understanding the triggers for incident pain, this can be anticipated and dealt with, for example by patients taking a dose of IR morphine about 20 minutes before the next "incident".

Opioid naive patients

Some patients will be opioid naive, that is, they may have severe pain but may have been taking only paracetamol, sometimes for reasons of denial (it happens) and failure to seek help. Alternatively their pain may have been adequately controlled with paracetamol but a sudden deterioration may have caused severe pain, for example vertebral collapse following metastatic bone disease, or a painful bleed. These patients should start on 5-10mg of IR morphine given four-hourly and titrated as above.

Sometimes an alternative is 20mg MR morphine twice daily (with IR morphine to top this up

if necessary). This can be increased by 33-50 per cent over a few days until control is reached.

Other strong opioids

Some doctors find oxycodone easier to use than morphine as its pharmacokinetics are less variable - oxycodone is better absorbed and more consistently metabolised. However, morphine remains the gold standard in pain control in palliative care because there is a wealth of experience in its use, and it is cheaper than oxycodone products.

When taken orally, oxycodone is around twice as strong as oral morphine (partly because of its better absorption and less complicated metabolism), so the dose should be half that of oral morphine. It is available as MR tablets (Oxycontin) and IR liquid concentrate or capsules (Oxynorm). The same rules apply as for using morphine with dose increases of 33-50 per cent when necessary at intervals of three days or more.

Hydromorphone is available as both MR and IR products (Palladone), but tends to be used less frequently than morphine or oxycodone. It is seven times as strong as morphine when used orally. Transdermal fentanyl patches provide continuous analgesia and can be an alternative to morphine. Fentanyl is very strong and there is no exact equivalence to morphine dose because of differences in the way individuals absorb and metabolise morphine. The lowest strength fentanyl patch (25mcg/hour) is roughly equivalent to about 90mg morphine/24 hours, but patients vary and care is needed when starting out. Some doctors see transdermal patches as a good alternative to oral morphine and switch patients on to 25mcg patches (or even more) without realising that this may be far too high a jump in dose, resulting in opioid toxicity.

Methadone is also used in severe cancer pain, particularly where there is a neuropathic element, but its use is best restricted to palliative specialists.

Diamorphine

Diamorphine is used when the oral route is not suitable, or occasionally when there is a sudden crisis or deterioration and rapid analgesia is required.

Morphine is not readily water-soluble, requiring large volumes for higher strength injections. In contrast, diamorphine is very soluble and is the drug of first

Skills for the

Future



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Medway School
of Pharmacy



7

Asthma



This module provides an illustrative case, a short overview of Asthma and a case study to test your ability to develop a care plan for a given patient. After completing this topic you will be able to:

- List the four aims of asthma management
- Discuss the mechanism of action and common side-effects of at least four drugs used in the treatment of asthma
- Select appropriate treatment for a given patient

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Course Details

- This is the seventh of 20 modules in the 'Skills for the Future' programme. Each module provides 1.5 hours of continuing education.
- A CD-rom containing case notes and video clips for several case studies, plus care plan templates, will be included in Module 14. Each case study will provide 10 hours of continuing education.
- Three care plans may be submitted for competency-based assessment by the Medway School of Pharmacy. Candidates who successfully complete the assessments will be awarded a Practice Certificate in Medicines Use Review. A fee of £60 is charged for assessment and certification, to be paid on submission of care plans.
- **Registration forms and Modules** can be downloaded from www.dotpharmacy.com. For further information call Mary Prebble, C&D, on **01732 377269** or e-mail the Course Administrator, Medway School at skills@medway.gre.ac.uk

Self-Assessment

Answers to Multiple Choice Questions

- a. TTFF
- b. TTTF
- c. TTFT
- d. FTFT
- e. TTTT

Care Plan for Mr WP

It would be appropriate to refer this patient to hospital immediately. Acute asthma management includes **SOS**

- Salbutamol 5mg and ipratropium 0.5mg via an oxygen-driven nebuliser
- Oxygen (high concentration ~60% if possible)
- Steroids- prednisolone 40-50mg orally or IV hydrocortisone 100mg. The intravenous route is rarely necessary but may be preferable if the patient is vomiting or unable to swallow.

This should be followed by blood gases, chest x-ray and repeated nebulisation if required. Treatment should never be delayed for investigations

arrhythmia, and of zidovudine, may occur without warning.

Theophylline is metabolised by the liver, and its half-life may be prolonged by specific disease states, such as heart failure and hepatic impairment. Enzyme inducers (phenytoin, carbamazepine, phenobarbitone and rifampicin) increase its hepatic metabolism, resulting in reduced plasma levels. Consequently, loss of therapeutic effect is possible during concomitant treatment with enzyme inducers.

In contrast, enzyme inhibitors (cimetidine, ciprofloxacin, metronidazole and erythromycin) inhibit metabolism and may increase blood levels, leading to toxicity. Enzyme inhibitors have a rapid onset of action (24–48 hours) and a rapid offset of effect (48–96 hours). It is important to avoid such combinations if possible. If it cannot be avoided, it is advisable to reduce the dose of theophylline to avoid toxicity.

Corticosteroids Corticosteroids are the primary 'preventer' mainstay of asthma management. They reduce airways inflammation. Inhaled corticosteroids delivered via a variety of devices are employed for long-term prophylaxis. Oral prednisolone is used to relieve acute attacks and exacerbations, with parenteral hydrocortisone reserved for emergency treatment of acute severe asthma in patients who are vomiting or unable to swallow.

Inhaled corticosteroids include beclometasone dipropionate, budesonide, fluticasone propionate and mometasone furoate. All are equally effective and take 3–7 days to produce their anti-inflammatory effect. To provide effective prophylaxis, these drugs must be taken regularly. Metered dose inhalers (MDIs) deposit >80% of their drug on the patient's pharynx. Using a spacer device ensures that a greater proportion of drug reaches the smaller airways.

Side-effects may include oral candidiasis (thrush) and dysphonia (hoarseness), both of which are linked to the use of high doses. Rinsing the mouth with water and brushing teeth after inhalation may help to reduce the incidence of oral

candidiasis. Very high doses of inhaled corticosteroids may expose patients to the full range of side-effects seen more commonly with oral dosing (see below). It is therefore important to use the lowest possible dose of inhaled corticosteroid to suppress airways inflammation.

When appropriate, a short course of oral prednisolone 40–50mg daily for five days is given to adults. The dose should be given as a single dose in the morning to mimic circadian cortisol production. To prevent relapse in patients with poor asthma control, the dose may be tapered off gradually. Longer term administration of oral steroids is linked with numerous adverse effects including peptic ulceration with perforation, osteoporosis, fluid retention and electrolyte disturbances, adrenal suppression, cataracts, hyperlipidaemia, impaired glucose tolerance, osteoporosis, skin thinning and purpura.

Refer to Chapter 6 (Glucocorticoid therapy) of the BNF for further information on side-effects. Oral corticosteroids are life-saving in severe asthma and should not be withheld.

Leukotriene receptor antagonists (LTRAs) Leukotrienes are all potent bronchoconstrictors. Montelukast 10mg daily and zafirlukast 20mg twice daily are LTRAs that are given orally to improve lung function. They are effective in asthma prophylaxis either alone or in combination with inhaled corticosteroids. They may be of benefit in exercise-induced asthma but are considered less effective in severe asthma. They are indicated as add-on therapy in mild to moderate asthma in those patients not controlled by inhaled steroids.

Leukotriene B₄ (LTB₄) attracts inflammatory cells into lung tissue. It is now thought that the leukotrienes contribute to the small airway pathology of asthma and that they are major mediators of both the early phase (bronchospasm) and the late phase (inflammation) of an asthmatic attack.

Common side-effects include gastro-intestinal disturbances, and headache. Refer to the BNF for details of rare serious adverse effects.

Case Study

Joe, a lively 9-year-old, uses a terbutaline Turbohaler as required. On attendance at the surgery, his PFR is 70% of normal. His mother is worried and complains that he has been waking up in the early hours of the morning over the last few nights. He has no other symptoms and, in particular, no evidence of infection.

Upon reflection...

Introduce low dose inhaled steroids.

Self-Assessment: Questions

For each of the following questions indicate whether the statement is true (T) or False (F).

a. The following are anti-inflammatory agents:

- Budesonide
- Nedocromil sodium
- Ipratropium bromide
- Salmeterol xinafoate

b. The following are bronchodilators:

- Theophylline
- Fenoterol
- Ipratropium
- Montelukast

c. Asthma symptoms tend to be:

- Intermittent
- Variable
- Associated with a fever
- Provoked by factors including exercise

d. The following statements refer to inhibitors of liver enzymes:

- They have a slow onset of action (2–4 weeks)
- They have a quick offset of action (48–96 hrs)

- Carbamazepine is an enzyme inhibitor

- Ciprofloxacin is an enzyme inhibitor

e. The following are recognised side-effects of bronchodilators:

- Tremor and palpitations with salbutamol
- Insomnia with theophylline
- Dry mouth with ipratropium
- Oral candidiasis with salmeterol

Self-Assessment: Care Plan

Mr WP, a 65-year-old male patient, has a history of asthma. His current medication includes salbutamol metered dose inhaler (MDI), as required, and beclometasone 250mcg MDI, two puffs four times daily. When measured this morning, his PFR was <50% and he then started on a short course of oral steroids, 40 mg prednisolone daily for five days. He presents in your pharmacy approximately 4 hours after initiating prednisolone, with wheeze, breathlessness and tachycardia.

What action would be appropriate?



References

1. British Guideline on the Management of Asthma, Scottish Intercollegiate Guidelines Network, The British Thoracic Society (2004), available at <http://www.bts.org.uk>

Useful websites

www.brit-thoracic.org.uk
British Thoracic Society

www.asthma.org.uk
National Asthma Campaign

www.asthma.org.uk/control
'Be in Control' materials

www.occupationalasthma.com
Occupational asthma lesson forms

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7

Approximate conversion chart for opioids

Patients should be monitored closely for signs of opioid toxicity

Morphine (oral) 24-hour dose	Oxycodone 24-hour dose	Fentanyl patch 72-hour patch	Diamorphine (subcut) 24-hour CSCI* dose
30mg	15mg (20mg)	None	10mg
60mg	30mg	25mcg/hr**	20mg
120mg	60mg	25 – 50mcg/hr	40mg
240mg	120mg	75mcg/hr	80mg
360mg	180mg	100mcg/hr	120mg

* CSCI Continuous Subcutaneous Infusion (ie 24-hour syringe driver dose)

** 25mcg/hr patch is equivalent to approx 90mg morphine salt, but this can vary between individuals

choice for the parenteral route.

Oral morphine undergoes extensive first-pass metabolism, which must be considered when converting to diamorphine injection from oral morphine. If switching to a syringe driver (continuous subcutaneous infusion (CSCI) of diamorphine), divide the total 24 hour dose of oral morphine by three to give the total 24-hour equivalent dose of parenteral diamorphine.

Thus, a patient taking MR morphine tablets 90mg twice daily, converted to a 24-hour CSCI of diamorphine (via a syringe driver) would need 60mg diamorphine in 24 hours (90mg multiplied by two divided by three). For patients who are deteriorating, some doctors might prescribe a dose of diamorphine equal to half the MR morphine dose, to allow for a dose increase at the same time.

Alternatively, the doctor may wish to prescribe four-hourly diamorphine doses. Again, the appropriate dose would be one sixth of the 24-hour equivalent dose – in the above example it would be 10mg.

Patients receiving diamorphine via a syringe driver may be prescribed 24-hour doses plus breakthrough doses. Thus, you might see different strengths of diamorphine on the same prescription, say 30mg + 5mg, or 100mg + 30mg + 10mg. It's important to check there is a clear dose for each strength, which identifies what each is to be for. Some ampoules may be intended for breakthrough "stat" doses,

equivalent to one sixth of the daily dose.

Information sources about use of opioids are included at the end of this article. If you are stuck or feel that things don't add up, it's worth contacting your local hospice where someone will be only too happy to help talk you through the dose equivalence.

Some important points

- Most terminally ill patients don't usually have diamorphine prescribed on FP10 out of the blue. If there is no record of previous increasing oral opioids on your PMR, challenge the prescription – even if it complies with the CD regulations and you know the prescriber and his signature. No one will mind explaining if the need is genuine.
- Some patients may receive prospectively prescribed drugs in anticipation of end-of-life symptoms or a sudden crisis. This is becoming more common to avoid the horror of out-of-hours emergencies, which only become "emergencies" because of lack of access to drugs. Anticipatory prescriptions are usually for small quantities and for more than one drug – it would be unusual for diamorphine to be prescribed on its own.

- Pharmacists tend to see the prescription and not the circumstances. Every prescription tells a story and pharmacists should be part of that story. By getting involved with GPs and nurses who look after terminally ill patients, and understanding where patients are in their cancer journey, you will understand their

prescriptions better.

- Doctors and nurses welcome pharmaceutical input. Admit what you don't know and they will help to fill in the gaps in your knowledge.

- Side effects of opioids such as nausea and vomiting (which may need an anti-emetic) and drowsiness usually abate after a week or so. Respiratory depression doesn't occur if doses are titrated slowly. Opioid-induced constipation is a fact of life and doesn't abate. All patients on regular opioids should be prescribed softener/stimulant laxatives routinely.

- A. Anti-emetic when starting opioids.
- B. Breakthrough pain (use short acting-opioid).
- C. Constipation (ensure softener/stimulant laxatives are prescribed).
- D. Diamorphine dose in syringe driver is one third of total regular + PRN oral morphine dose over 24 hours.

How can pharmacists help prevent another Shipman tragedy? The simple answer is that they probably can't – a serial killer will presumably always be one step ahead. But there are some clues, which, while they may not necessarily prevent a future Shipman, will nevertheless help support better palliative care. An increasing number of terminally ill patients want to die at home. It's important that patients and those who care for

them have access to drugs required for symptom control, together with relevant information for their safe and effective use.

Useful resources:

- British National Formulary, current edition. *Guidance on prescribing in palliative care.*
- The Palliative Care Formulary, second edition or www.palliativedrugs.com
- Improving supportive and palliative care for adults with cancer. (NICE Guidelines). March 2004. www.nice.org.uk
- Macmillan/DoH Gold Standards Framework. www.macmillan.org.uk

Mary Allen is a part-time community pharmacist and hospice pharmacist in Herts.

Actionplan

1. Read the BNF sections on "Prescribing in palliative care" and "opioid analgesics" 4.7.3.
2. Consider the pros and cons of having a "balance/current stock level" column in your CD register. If there are no disadvantages, consider why we do not have such records in the UK. Is it just a historical fact?
3. List in your practice workbook the key points that would alert you to unusual supply requests.
4. Do you or have you supplied CDs to terminally ill patients? Is/was the supply pattern in line with that suggested in the article? If not, how does it/did it vary? Having read the article, do you now have misgivings in this case? What should you do about it?
5. In your practice workbook, list opioids used as adjuvant analgesics, their doses for this purpose and their side actions. How do these drugs assist pain control?
6. List the problems of "by the clock" administration. What should you do if the prescriber fails to take these problems into account?

Distance Learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are encouraged to be tested with the support of Genus Pharmaceuticals. C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the October 2 issue, which will cover this week's OPP-audited material together with those in the September 11 and 18 issues. These will cover:

- Endometriosis (1314) ● Incontinence (1315) ● Controlled Drugs (1316).

A telephone marking service offers independent verification of results – details on the monthly MCQ paper.

People wanting to register for Pharmacy Update can contact Mary Prebble on 01792 377260.

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Children's NSF involves pharmacist input



Pharmacists will have a significant role to play in implementing the *National Service Framework for Children, Young People and Maternity Services*, published earlier this month.

Medicines management, promoting healthier lifestyles and giving advice on medicines use are

all areas covered by the *NSF* in which pharmacists will be able to be involved.

The *NSF* recommends pharmacists' expertise should be used "in commissioning medicine management services for children and in supporting wider health promotion strategies

for children and young people".

In addition, the *NSF* recommends that PCTs ensure schools have access to advice, training and support from healthcare professionals including pharmacists on medicines used by pupils while in school.

David Pruce, RPSGB's practice and quality improvement director, told *C&D* this could mean pharmacists offering advice to schools in a similar way to care homes,

and as a service paid for by the PCT. This could include advice on the appropriate storage of medicines and advice for teachers.

Mr Pruce said pharmacists can help parents and children understand that medication being used off-licence is suitable for children. The working group for

the *NSF* and the Society want to see leaflets and other forms of information developed around off-label uses for pharmacists to give to parents and children, he added.

The standards set out in the document are intended to empower children and their parents with information and choice on the support and treatment they receive. These also include improved access to services, a focus on early intervention, promoting healthier lifestyles and tackling health inequalities.

"This is the first *NSF* which has specifically had medicines management so prominent. It is a real victory getting pharmacy and medicines so prominent in an *NSF*," he concluded.

The *NSF* should be implemented by all NHS Trusts and local authorities in England over the next 10 years, although when and how will be determined locally.

For more information:

www.dh.gov.uk

Evra link to 17 deaths

Contraceptive patch Evra has been linked to 17 deaths, but the manufacturer says the side effect profile is similar to other forms of hormonal contraception.

According to the *Metro* newspaper, the US Food and Drug Administration has linked Evra (norelgestromin and ethinylestradiol) to 17 deaths and 21 incidences including blood clots.

A spokeswoman from

manufacturer Janssen-Cilag said Evra's side effect profile was consistent with other hormonal contraception and the company was continuing to look at all reported adverse events. She warned that the numbers may contain duplicate cases. Because of confidentiality it was difficult to determine the accurate number of adverse events and there may or may not be new reported cases. She added that women who use

Evra do not need to see their GP urgently, but if they are concerned, should make a routine appointment.

A spokeswoman from fpa, formerly known as the Family Planning Association, offered this advice: "Don't jump to any conclusions, don't stop using your patch. If you are worried seek advice from your practice nurse, GP or family planning centre."

Europe gives initial nod to two drugs

The European pre-approval committee for medicines has recommended an antidepressant and an HIV drug be considered by the European Commission.

The Committee for Medicinal Products for Human Use (CHMP) has given a positive opinion on Eli Lilly's antidepressant Cymbalta

(venlafaxine hydrochloride) and Bristol-Myers Squibb's once-daily

antiretroviral treatment for HIV.

Before the products can be launched, the European Commission's approval is required. Lilly estimates this could be within the next few months. Its selective serotonin and noradrenaline reuptake inhibitor Cymbalta was recently launched in the USA.

In addition, CHMP gave a positive opinion on extending the licence for Taxotere

(docetaxel) for use in combination with prednisone or prednisolone for patients with hormone refractory metastatic prostate cancer.

● GSK and Roche have submitted a once-monthly oral version of their osteoporosis treatment Bonviva (ibandronate) for marketing approval from the MHRA.

For more information:

www.emea.eu.int

Gel may end injections

Injections for patients with conditions such as diabetes and Crohn's disease could be replaced by an oral gel that delivers the drugs, claim Indian researchers.

The drug is loaded onto the terpolymeric hydrogel, which is strong enough to resist breakdown by the stomach's gastric fluids. Over half of the drug is released where it is needed in the colon. The colon's high pH causes the gel to swell and release the drug.

The researchers claim the gel will avoid issues with concomitant medication affecting blood serum concentrations of a drug because the gel produces a targeted, controlled release of the drug. So far it has only been tested with vitamin B₁₂, but the researchers are hopeful that *in vivo* studies will show the system can be modified to produce oral pills for conditions such as ulcerative colitis, bowel cancer and Crohn's disease.

For more information:

<http://interscience.wiley.com/polymerinternational>

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Night coughs nursed by GSK

GlaxoSmithKline Consumer Healthcare is extending its Nurses range with a pharmacy-only night-time cough relief product.

Cough Nurse Night Time Liquid contains diphenhydramine 50mg and pholcodine 15mg per 20ml dose.

The launch will be supported by a £0.8 million launch package including radio, press and Pharmasite posters from



December.

Eye-catching point of sale material includes countertop units, posters and wobblers.

GSK recommends merchandising the product alongside Night Nurse to create a distinct section for night-time cold and flu treatments.

Price: £3.99

Pack size: 150ml

Pip code: 305-7429

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

One-pill Levonelle simplifies contraception

A one-pill dose of Levonelle will be launched exclusively through pharmacies in November.

Levonelle One-Step will replace the existing two-pill format and offer greater convenience for women. A single tablet contains levonorgestrel 1,500mcg. The product will come in new packaging and will be phased in as stocks of the two-tablet product run out.

It is being introduced at the time of year when emergency hormonal contraception is in greatest demand. Schering Health Care says sales data shows usage jumped by 107 per cent in the days immediately after last

Christmas and New Year.

The product will be supported by a £300,000 advertising and promotional campaign including posters on the London Underground and at commuter train stations in mid-November and over the Christmas/New Year period.

Price: £25.00

Pack size: one tablet

Schering Health Care Ltd

Tel: 01444

232323



Glucosamine supplement for vegetarians

Health Perception is targeting the four million vegetarians in the UK with its launch of vegetarian 750mg glucosamine tablets to help maintain joint mobility.

High Strength Vegetarian Glucosamine contains glucosamine hydrochloride 750mg and manganese 2mg.

The product is formulated with non-shellfish glucosamine manufactured from a naturally occurring vegetarian source. The tablets are suitable for sufferers of seafood allergies and

those not permitted to eat fish due to religious beliefs.

Vanessa Brown, corporate relations manager of the Vegetarian Society comments: "This is an exciting development as vegetarians have not been able to take advantage of the benefits of glucosamine to maintain joint mobility until now."

Price: 30 tablets

£10.99, 60 tablets

£15.99, 90 tablets

£20.99



Health Perception Ltd
Tel: 01252 861454

Bourjois gets intense with liquid lipcolour

Bourjois is launching an intense liquid lipcolour range in November.

Rouge Pop Chic is formulated to provide an ultra-lacquered, high gloss result. The non-sticky lipstick contains vitamin E and lavender derivatives to help protect and improve the appearance of the lips. It is presented in a transparent

tube that highlights the colour of the lipstick inside. The tube features a flat brush designed to allow precise application and create a smooth, even result.

Price: £6.95

Pack size: 4.5ml

Bourjois Ltd

Tel: 020 7436 6110

Keep cool under pressure

Trebleframe is launching a range of products for muscular injuries due to everyday stresses and sports injuries. The Ice Power range comprises three products – Cold Gel (in two sizes), Cold

Spray and Gel Roll-on.

Price: Cold Gel £6.99 (75ml), £9.99 (150ml), Cold Spray (200ml) and Gel Roll-on (75ml) £7.99

Trebleframe Ltd

Tel: 0845 6440392

TVnext week

Aquafresh: All areas except U, CTV, GMTV

Astral Moisturiser: C4, five, GMTV

Bassett's Soft & Chewy vitamins: GMTV, Sat

Bisodol: Sat

Bodyform: C4, five, GMTV, Sat

Brolene Cool Eyes: GMTV, Sat

Canesten Duo: All areas except CTV

Lucozade Sport: All areas except U, CTV, C4, five, GMTV

NiQuitin CQ: GMTV, Sat

Setlers: five, GMTV

Seven Seas Cod Liver Oil: All areas except GMTV

Syndol: All areas

XLS dietary supplement: GMTV

PharmaSite for next week: NiQuitin CQ – window, **Heartburn Care range** – in-store, **Metanium** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire



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Web link for skin flare-up sufferers

GlaxoSmithKline Consumer Healthcare has relaunched its website for Eumovate Eczema and Dermatitis Cream and Eumobase and linked it to a range of advertising initiatives.

www.skinflareup.co.uk has a fresh new look and has been updated to ease navigation and engage consumers more fully, says GSK. Visitors will be directed to the site via consumer press advertorials and banner advertising on related sites.

Once on the site, consumers will be invited to apply for a £0.60 money off coupon redeemable against Eumovate Eczema and Dermatitis Cream (15g) in return for



the submission of helpful data with information about their condition.

The initiative is designed to help GSK gain a greater understanding of the skin flare-up sufferer.

For more information:

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Online boost for Bodyform

SCA Hygiene Products is relaunching its Bodyform website www.bodyform.co.uk on October 4.

Based on the 'Wear Bodyform' concept launched in TV and print, the site will allow women to choose product samples, enter online forum discussions and take part in constantly evolving opinion polls and competitions.

Visitors can also request advice from a professional source on health, beauty and relationships.

An online micro-site competition will support the relaunch from October 4 until October 29. Entrants will have to put together



three confidence boosting outfits using a 'wardrobe' of clothes. First prize includes £250 of Arcadia Group vouchers.

For more information:

SCA Hygiene Products Ltd
Tel: 01582 677400

Help for the menopause

Chefaro is targeting women aged 45-65 with a natural supplement for menopausal symptoms.

Ymea capsules may help maintain harmony and balance before, during and after the menopause. Formulated to be rich in natural isoflavones, the capsules contain extracts of three plants – soya, hops and melon.

A point of sale unit and leaflets



will be available for independent pharmacies in October.

Pharmacies which order directly through Chefaro will receive special

packs with a free pill box attached.

Price: £12.95

Pack size: 64 capsules

Pip code: 307-3368

Chefaro UK Ltd

Tel: 01480 421800

TRESemmé goes style crazy

Alberto-Culver is expanding its TRESemmé haircare range with four new styling products in October.

Extra Control Mousse is a light mousse to add body, control and shine to the hair. Volume & Lift Mousse is formulated to provide extra body, lasting volume and shine.

Both products contain provitamin B5 and UV filter to help protect the hair against over-styling and environmental damage.

Salon Finish Hairspray Extra Hold provides firm hold while Salon Finish Hairspray Natural Hold is designed for long-lasting touchable hold.

Both products are fast drying, water-free finishing sprays.

Price: All products £3.99

Alberto-Culver Co UK Ltd

Tel: 01256 705000

Inbrel Cleverwhite on TV

Chefaro is supporting its Cleverwhite one-step tooth whitening system with an £850,000 TV advertising campaign.

Targeted at women aged 25-44, the commercial will be on air from October 4 until December 12.

For more information:

Chefaro UK Ltd

Tel: 01480 421800

Breathe easy

Ceuta Healthcare will back its Breathe Right nasal strips this winter with a TV campaign in December and January. The advertising is designed to convey that Breathe Right nasal strips can help clear night-time nasal congestion caused by colds, flu and sinusitis. The TV campaign will be reinforced with sampling activity.

For more information:

Laser Healthcare

Tel: 01202 780558

Promotion

New Vegetarian Glucosamine from Health Perception – ahead of the field, naturally

Health Perception, the nutritional supplement company who originally introduced glucosamine into the UK, are now launching the UK's first ever vegetarian 750mg glucosamine tablet.

With the seal of approval from The Vegetarian Society, this long awaited supplement will thrill those who to date have been excluded from the known benefits of glucosamine. Vanessa Brown, Corporate Relations Manager of The Vegetarian Society, said: "With approximately four million vegetarians in UK, we welcome Health Perception's new **High Strength Vegetarian GlucOsamine**. This is an exciting development as vegetarians have not been able to take advantage of the benefits of glucosamine to maintain joint mobility – until now."

Health Perception's Marketing Director, Helen Isaac, added: "We believe part of our success is due to the fact that we continue to offer our customers the widest choice of glucosamine products and a non-shellfish glucosamine was a natural progression in the development of our range."

For sufferers of seafood allergies and those who are not permitted to eat fish due to religious beliefs, this product will be a welcome

breakthrough. The product has been certified 'kosher'.

Health Perception's **High Strength Vegetarian GlucOsamine** provides the non toxic biochemical constituent glucosamine, which is manufactured from a naturally occurring vegetarian source. Health Perception, whose glucosamine range is the most comprehensive in the UK, has chosen glucosamine hydrochloride (HCL) for the new vegetarian product, which is naturally stable and, in line with their corporate philosophy, has a particularly high purity.

High Strength Vegetarian GlucOsamine is available in packs of 30, 60 and 90 tablets, with each tablet providing 750mg Glucosamine Hydrochloride and 2mg Manganese, the essential trace mineral shown to enhance the bioavailability of supplemented nutrients through increased absorption.



headMASTER!



Recommend Lyclear to your customers and help teach head lice a lesson they won't forget!

Lyclear (permethrin) is the only 10-minute treatment available over-the-counter, which unlike many other treatments, is not contraindicated in those with asthma. The orange cream is simply applied to damp hair for just 10 minutes, killing lice and their eggs with just one application.

So, the next time your customers ask you about head lice, show them who's in charge with Lyclear!

The 10-minute treatment for head lice that's in a class of its own

Product Information: Lyclear Creme Rinse. **Presentation:** A light orange coloured topical cream containing the active ingredient Permethrin 1% w/w. **Posology and administration:** One 59ml bottle is usually sufficient to treat one person with shoulder length hair of average thickness. Also available in a twin pack containing 2 x 59ml bottles. Suitable for adults and children over 6 months of age, also suitable for asthmatics. Children under 6 months of age should be treated on the advice of a doctor. Shake thoroughly and apply to washed, towel dried hair. Leave on hair for 10 minutes before rinsing thoroughly with water. **Uses:** For the treatment of infections with the head louse *pediculus humanus capitis*.

Contraindications: Individuals with known hypersensitivity to the product, its components and other pyrethroids or pyrethrins. **Precautions:** If accidentally introduced into the eyes, rinse immediately with plenty of water. For external use only. Shake thoroughly before using. If symptoms persist consult your doctor. Keep out of reach of children. **Legal category:** P. **Product licence number:** 15513/0019. **Product licence holder:** Pfizer Consumer Healthcare, Eastleigh, Hampshire, SO53 3ZQ. **Package quantity and RSP:** 59ml is £3.99 and the twin pack (2x59ml) is £7.25.

**WIN
A SPA DAY
FOR TWO!**



Are you vit enough?

To keep vitamin sales in good shape and win a spa day for two, read on...

The UK vitamins and minerals market is worth £400 million*, which means a healthy profit available to all pharmacists – but are you maximising sales opportunities? Top selling brands draw the customer to the fixture. Key brands to stock are:



Berocca
The UK's
No.1 selling
Energy brand

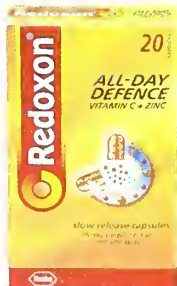


Sanatogen
The UK's No.1 selling
Adult Multivitamin
brand



ProNatal
The UK's No.1
selling Pregnancy
supplement

Redoxon
The UK's No.1
selling Vitamin
C brand



For the chance to win a day of self-indulgence for you and a friend, with full use of spa facilities, a beauty treatment and lunch, simply answer the question below:

Q Name the UK's No.1 selling pregnancy supplement

Send your answer on a postcard, with name and address, to:
Roche VMS Competition, 15-17 Huntsworth Mews,
London NW1 6DD by 25 October 2004

Sanatogen, Sanatogen ProNatal, Berocca, Vital 50+ and Redoxon are registered trademarks. 1. Source: IRI All Outlets, 52 w/e 10 July Value Sales (Applies to all brands except ProNatal). 2. Source: IRI All Outlets, 12 w/e 10 July Unit Sales (Applies to ProNatal only).

Terms & Conditions

You must be aged 16 years or over and normally a resident in the UK to enter. Employees of Roche group companies or any other person professionally associated with this prize draw, their agents and their families are not eligible to enter the prize draw. Only one entry per person is permitted. Proof of sending an entry is not proof of our receipt of entry. No possibility can be accepted for entries that are lost, delayed or incomplete. The closing date is 25 October 2004. The winner will be drawn at random and notified by post 14 days of the closing date. The prize may not be claimed by any other person. No purchase is necessary. An alternative or alternative prize is available upon an equivalent but in the event of the advertised prize being unavailable we reserve the right to offer an alternative prize of equal or greater value. Winners may be required to take part in a publicity campaign. The prize must be claimed by 30 November 2004 and 30 May 2005. We provide no guarantee that the prize will be

available on any particular day selected. Use of false names or addresses will disqualify you from receiving any prize. We reserve the right to amend these rules at any time. Entry implies acceptance of these rules. The winner's name and county can be obtained by writing to Sarah Murphy, Counsel, 15-17 Huntsworth Mews, London NW1 6DD. The promoter of the prize draw is Roche Products Limited of 40 Broadwater Road, Welwyn Garden City, Herts AL7 3AY. Your personal details will be retained for a reasonable period of time (a) to supply you with any prize if your name is chosen as the prize-winner and (b) to ensure compliance with these terms and conditions. We will not disclose your personal details to any third party other than as necessary to supply you with your prize in the event of you being the winner. Whilst the winner is at the health spa, all liability for any loss or personal injury will be the sole responsibility of the health spa and Roche shall have no liability whatsoever, except due to its own negligence. Your statutory rights are not affected.



Chemist Druggist



Walking into Seamus Strain's pharmacy you'd never guess the store was razed to the ground when a chip-shop fire destroyed part of the village.

Two years later, Camlough Pharmacy is just how you'd like a pharmacy to look and feel. Mr Strain describes it as a "Rolls Royce pharmacy with the wow factor". There is a modern interior, but it retains traditional discreet areas for medicines and beauty products. It uses primary colours, dark wood trims and clean white tiled floors, yet remains welcoming and retains the right clinical feel. And it is spacious.

Popular with the masses

In fact, Camlough's redesign has been popular with customers, staff and awards judges alike. Customers love the new-look pharmacy with its additional features such as a community health suite. Some of them even played a part in rebuilding it. The staff enjoy working there just as much as they enjoy cups of tea in their new, and rather lovely, staff room. The trophy cabinet speaks for itself: Camlough Pharmacy has received awards from the *Ulster Chemist's Review*, Neighbourhood awards and, most recently, the *C&D Platinum Pharmacy Design Award*.

The *C&D* judges – editor Charles Gladwin, NPA chairman John D'Arcy, Ceuta Healthcare Group chairman David Mair, and National Association of Shopfitters vice-chairman Vaughan Chopping – felt the designers "really seized the opportunity they were presented with".

It didn't feel like much of an opportunity when pharmacist Seamus and his wife Margaret returned from holiday to find their pharmacy of 15 years reduced to a pile of ash.

"The staff were holding their heads low, they thought their jobs were gone. But I said 'hold on a wee second, we're just going to have to work harder' and it was all hands on deck", remembers Mr Strain.

Before the Strains had arrived back at Camlough, a pharmacist friend John Swail had established a temporary premises in the nearby car park, fitted it out and arranged insurance and it opened five days after the fire. There was a real team effort involved in getting the pharmacy back on its



The £75,000 refit has had a positive impact on profitability

feet, explains Mr Strain. "A lot of goodwill from the local people – joiners, people doing the floors, they all got stuck in. My brother-in-law built the staircase. Public support was overwhelming."

Right from the start Mr Strain was adamant he was keeping all of his staff on, and they rewarded him with hard work and dedication. "I can't praise the staff highly enough. They were here until two and three in the morning. We had staff meetings on design, floor tiles etc. They made a major input – the girls were invaluable."

Like a phoenix

When a fire destroyed his pharmacy, Seamus Strain seized the chance to create a 'Rolls Royce' store. He talks to **Fiona Salvage** about what it's like to win the prestigious Platinum Pharmacy Design Award



Primary colours and dark wood trim feature in the modern interior which has proved popular with customers, staff and awards judges alike



The customers got involved in the redesign process too. "We gave the customers a questionnaire asking them what they would like to see, what services they wanted."

Research was important

Researching the redesign was important to Mr Strain and he spent hours travelling the length and breadth of Ireland armed with a camcorder and a notebook looking at recently refitted pharmacies for ideas and inspiration.

In the end, the designer who won the project met Mr Strain by chance when he arrived to sell another product, HealthPoint. Keith Anderson proposed a "different concept" for the pharmacy, says Mr Strain. Anderson Retail Consultants had done a lot of

design work in Southern Ireland, but hadn't yet moved into the Northern Ireland market.

Mr Anderson says that Mr Strain was an "excellent customer to work for. He was very forward thinking and gave us the scope to do something innovative. Our brief was to design a concept for an individually branded and customer-focused shop with a modern healthcare image, while retaining the character of a rural community pharmacy".

He adds that Mr Strain recognised the benefits of employing a separate specialist designer which has resulted in excellent returns on his investment and substantial savings on the shopfitting costs.

The contract for the shop fitting was put out to tender and in the end Prime Shop Interiors,

which Mr Strain had worked with before, came out top. "Brendan Bracken, the director, was very keen to get as much information as possible. We had a track record and everything worked according to plan."

The project was completed in just under three weeks, helped along by the pharmacy running from temporary premises so the process could be more "methodical". As a ballpark figure, Mr Strain estimates the refit cost £75,000. The impact on sales has been positive though. Mr Strain estimates prescription volumes have risen by up to 15 per cent, and turnover for OTC products is up as much as 60 per cent. Naturally overheads

Continued on page 34 ►



With a clean slate to work from, the veterinary counter was given its own entrance in the redesign



have increased too, but overall profitability is up in the region of one third.

The fire provided the designers with a clean slate to work with and Mr Strain's negotiations with his landlord freed up even more floorspace by doing away with a back store.

The floorspace in the pharmacy increased from 2,000sq ft to 3,000sq ft and the original L-shape became squarer. It was important not to have any "cold spots" in the store so the dispensary was moved towards the rear, explains Mr Strain. Just behind this is the veterinary counter, which has its own entrance. "The farmers are seen quickly – five steps and they're at the counter – and if their boots are mucky they don't feel inhibited. It hasn't raised any consternation with the beauty customers, but it does mean you need to have eyes in the back of your head."

The Clarins counter and the other beauty products are at the front of the store, over on the right between the front windows and the lift. As unglamorous as it sounds, this is actually ideal. "It has privacy, it is not in the public glare and the lift goes up to the beauty

room." Also upstairs is the community health suite, which really helps to bring all members of the surrounding communities into the pharmacy.

"We've had advice on childminding, a first aid course, a sign language course which some of the staff went on, information sessions on cardiac risk factors and beauty information sessions." The room itself is well equipped with plenty of seats, a couple of comfy sofas, reading materials on any medical condition you'd care to name, a whiteboard and even a PC. Although the room is "still in its infancy" Mr Strain thinks maybe "occupancy rates could be higher, but I see fantastic potential in it".

Professional services

In front of the dispensary and to the side of the counter there is a clever swirl of wall that houses the consulting area. This and the extra rooms upstairs are very important as Camlough Pharmacy offers many professional

services. On Thursday mornings Camlough's second pharmacist, Dermot Smith, runs his brainchild: PharmaHealth Promotion.

Colloquially known as a "health MOT", it consists of a complete series of diagnostic tests. It places primary importance on smoking cessation, but also covers blood pressure, blood glucose, lipid profile, BMI and healthy living advice.

"It started a couple of weeks ago and it booked up. There's been a significant demand," says Mr Strain.

A two-pharmacist operation is important to Camlough: "There's no way it could be done single-handed." But, he admits, "profitabilities must be within the system" to support this way of working. Pharmacies offer "an important range of services and filter out some of the patients from the GP waiting rooms so GPs see only those who need to be seen", he adds.

Camlough has been involved in a scheme to refer children under five years old with dental caries who are unregistered with a dentist. Mr Strain hopes to become involved with a minor ailments scheme, to be run in partnership with GPs towards the end of this year.

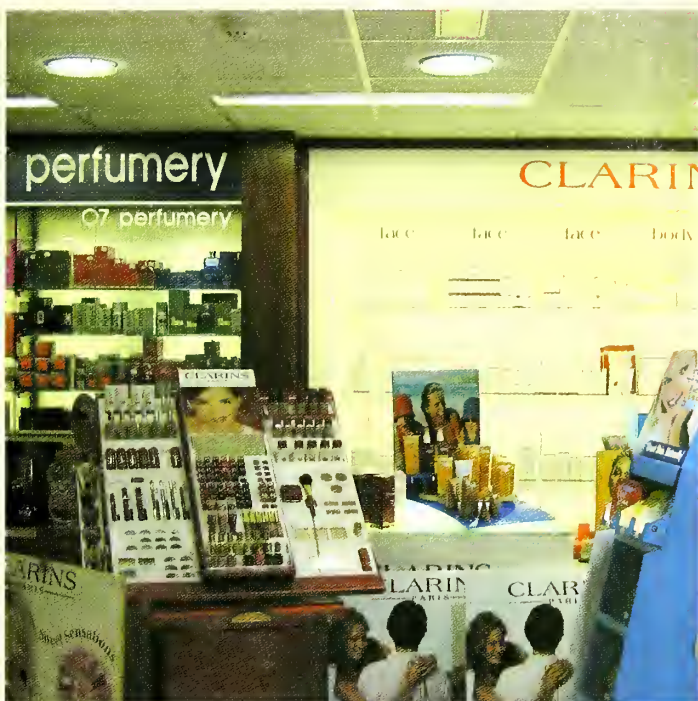
The future

On the drive into Newry, the nearest town to Camlough, there is a sign which says "Newry, the small city with a big future." Camlough is a small village with a pharmacist who envisaged a big future for his pharmacy. Mr Strain passionately believes in the changes happening to pharmacy and encourages other pharmacists to "think outside the box".

"There are fantastic opportunities. The ranks have been very conservative, quite rightly, as it is important that they give due consideration to what is taking place and changes are well researched and we don't jump in with our eyes closed. But it is equally important not to drag our feet and lose out in



Strain with his staff: "They made a major input"



The Clarins counter is at the front of the store

the future. We need to strike a balance."

Personally speaking, Mr Strain thinks medicines management will become the cornerstone of pharmacy in the future, along with chronic disease management with other members of the primary care team. But there are a few niggles to sort out. "If pharmacists are to come on board, they need to be more flexible in terms of their working day. Also, pharmacists haven't got a significant infrastructure for practicalities - more help would encourage more to get on board," says Mr Strain.

Reflections and advice

Seamus Strain came through a complete refit of his pharmacy

and is even managing to look to the future. With a quick glance to the past, and the benefit of hindsight, is there anything he'd do differently - other than not coming home from holiday to a burnt-out pharmacy? "No I wouldn't do anything differently. I'm quite happy with the way everything is going." Any advice for pharmacists considering a major refit? "Get plenty of advice if you're spending a significant amount. The first port of call was the NPA planning department. Neil Williamson's advice was invaluable. I wouldn't let a shopfitter through the door before the NPA planning department. Advice costs money, but it's small fry. Don't be afraid, invest in the planning stage as it's the most important." ☺

Even the young are catered for - the pharmacy is involved in a scheme to refer children with dental caries



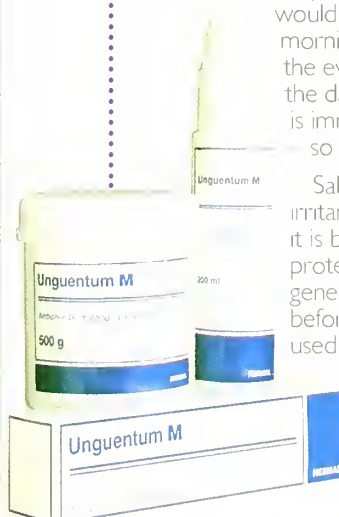
I am going on holiday soon and I am worried about my eczema - can I use Unguentum M with my sunscreen? Also, is it safe to go swimming with Unguentum M on my skin or would this worsen the skin condition?

Some people find that their eczema improves in the sun and others find that it gets worse. Either way, your skin will need protection from the sun and possibly also from the irritant effects of salt, sand, chlorine and sweat.

Exposure to the sun can have a marked drying effect on the skin so you will need to use more moisturiser than usual. You may also need a richer emollient. Unguentum M is a particularly good choice here because it combines the spreadability of a cream, with the high fat content of an ointment. It will keep your skin smooth and supple without feeling greasy.

Unguentum M can be applied safely with a sunscreen but it should be applied about half an hour before. Separating the applications in this way ensures that the emollient sinks into the skin and does not dilute the sunscreen. The way to get the best out of the treatment would be to apply Unguentum M in the morning, before applying the sunscreen, in the evening and as often as required during the day. A good time to apply an emollient is immediately after showering or bathing so that moisture is 'sealed' in.

Salt-water, sand and chlorine can all be irritants to eczematous skin, especially if it is broken or cracked. One way to protect damaged skin is to apply a generous layer of emollient to the area before swimming. Unguentum M can be used safely in this way and will help to protect the skin from the irritant effects of salt and chlorine.



Prescribing information

Unguentum M is an ambiphilic topical preparation with emollient properties which contains the high lipid content of an ointment but also has the water-miscible characteristics of a cream.

Contains: Purified water, white soft paraffin, cetostearyl alcohol, poly sorbate 40, propylene glycol, glycerol monostearate 40/55, liquid paraffin, medium-chain triglycerides, sorbic acid, colloidal anhydrous silica, sodium hydroxide.

Uses: Unguentum M has emollient properties and is recommended for the symptomatic treatment of dermatitis, nappy rash, ichthyosis, eczema, protection of raw and abraded skin areas, pruritus and related skin conditions where dry scaly skin is a problem, and as a pre-bathing emollient for dry eczematous skin, to alleviate drying effects. It is also used as a diluent for various topical corticosteroid formulations where a lower strength preparation is required and as a general base for extemporaneous dispensing.

Dosage and administration: A thin application of cream should be gently massaged into the skin three times daily or at appropriate intervals. When used as a protective cream, Unguentum M should be applied sparingly to the affected area of the skin before, or immediately after, exposure to the irritant factor.

Contraindications, warnings etc: Unguentum M should not be used in patients with known allergy to the ingredients.

Undesirable effects: None known.

Package quantities: 50g and 250g tube, 250g tub and 200ml pump pack.

Basic NHS cost: 50g £1.00, 250g tube £1.95, 200ml £6.19.

Legal category: GSL.

Product licence number: PL 0001, 0001/13.

Product licence holder: Crookes Healthcare Ltd, Nottingham NG2 2AA.

Date of preparation of this item: Sep 2004.



Changing
faces



Changing
faces

The charity Changing Faces provides learning material, books and posters on disfigurement

Face value

In the fourth article in our series, Cathy Wheatley from Changing Faces looks at how disfigurement fits into the Disability Discrimination Act

When we think about disability, we rarely associate it with disfigurement. However, the DDA states that severe disfigurement should be treated as if it were a disability. It is therefore unlawful to discriminate on the grounds of someone's looks in both the quality of service received and in employment. With the next phase of the Act coming into effect from October 2004, all pharmacists will need to make sure that their customer service and employment policies take this into account.

Approximately 400,000 people in Britain have disfigurements to their face, hands or body. Some people are born with a disfiguring condition while others acquire a disfigurement through accident, illness, skin conditions or surgery. Many people don't know how to react to someone who has a disfigurement. Common reactions include embarrassment, excessive staring, avoidance or even intimidation. If pharmacists don't address this, someone on the receiving end of such behaviour could see it as discrimination and decide to be within their rights to take action.

Pharmacists should not let their lack of experience of disfigurement get in the way of ensuring best practice in customer service and employing the best person for the job. In relation to people with disfigurement, pharmacists should start with:

- acknowledging the lack of knowledge and understanding about disfigurement that lies behind people's attitudes and behaviours
- recognising that employing a person with a disfigurement or offering them a quality service can bring very positive benefits to an organisation
- working in ways that support diversity and equality in the workplace.

Disfigured customers

To enable your staff to become confident and skilled in giving an appropriate and efficient service, pharmacists can take the following steps:

- Provide staff with information which helps them to understand the experience of disfigurement and gives them advice on what to say and do when they serve

someone who has a disfigurement.

- Offer disfigurement awareness training to equip staff with practical tools and communication skills so that that they can interact confidently with their customers with disfigurements.
- Review existing customer service policies and practice by consulting with customers who have disfigurements or charities like Changing Faces and talk to front-line employees to gain input on the quality of service the organisation offers and where changes are needed.

Employment issues

People who have disfigurements are unlikely to need special facilities or equipment to perform their work yet many experience limited job offers and lack of promotion as a result of wrong assumptions being made about their capabilities. Others will only be offered background jobs with little chance of working with colleagues or customers, so no one can learn how to interact with each other effectively.

"Some people with disfigurements expect a shocked reaction when they reach the interview stage"

In reality, many people with disfigurements have well-developed communication skills and have learned how to make people feel at ease in difficult situations. These skills could make them particularly valuable as staff members or when serving customers.

Successful recruitment needs to start with the job description which should focus on required skills and abilities. When processing applications, make sure those involved have had disfigurement awareness training, that the process only asks for relevant information and that it is conducted in a non-discriminatory way. Prior training for the interviewer and the panel is also vital to ensure that all applicants get a fair chance to show you why they are suitable for the vacancy.

Some people with disfigurements expect a shocked reaction when they reach the interview stage and have developed very effective ways to handle it, putting the interviewer at ease and getting the meeting back to business. In the same way, confident interviewers greet the applicant as they would any other person, pose the same questions to each applicant and acknowledge their disfigurement by asking open questions about

how they manage it while giving the applicant every opportunity to tell them about the skills and talents which could be valuable to their organisation.

The workplace

A co-ordinated and collaborative approach is the most successful way to manage the retention of individual employees, including people with disfigurements, and to avoid discrimination as the example shows (see panel).

Many organisations and businesses now see the benefit of diversity in the workplace. Diversity across the workforce means having access to a wider pool of employees together with experience that will attract a wider customer base. Equally, businesses and organisations that show they value all individuals and customers, including those with disfigurement, will be more attractive than those that do not.

Best practice should be built into and reinforced by the culture of the organisation. With a cultural change, which underpins changes in the thinking and actions of all individual members of staff, best practice can be effectively sustained for all aspects of

Case study

Changing Faces was approached by Sainsbury's head office. A young management trainee in one of their regional offices had severe burn scars on one side of his face. The store manager contacted Changing Faces to ask for advice on what reasonable adjustments could be made for this trainee. We provided booklets for distribution to relevant staff to inform them about disfigurement and also advised him to talk to the trainee about what adjustments he would like to see made. The trainee asked for a statement informing colleagues about his experience to be circulated. Sainsbury's followed good practice by taking steps to ensure that everyone concerned had the information they needed to feel comfortable and reassured and to enable the trainee manager to get on with the job.

disability, including disfigurement.

Changing Faces is the national charity supporting and representing people who have disfigurements. Our aim is to enable everyone to face disfigurement with confidence – whether or not they have a disfiguring condition.

For further information on our work with employers and employees or to purchase a copy of Changing Faces' Guides to Disfigurement for Employers, please contact Changing Faces on 0845 450 0275 or e-mail info@wchangingfaces.co.uk.

AAH

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VANTAGE

The 2005 AAH Pharmaceuticals Convention



Sintra 2005 Navigating in the New World

17th May – 22nd May 2005, Sintra, Portugal
Ritz Carlton Penha Longa Hotel & Golf Resort

Following the unprecedented success of the Monaco 2004 convention, AAH and Vantage are pleased to announce Sintra, Portugal as the destination for their 2005 convention.

Sintra is a charming and tranquil town, resting on a lush mountain cloaked in scented pine forests. It is renowned for its associations with great kings and noblemen and as such, encompasses many palaces, churches and the spectacular Pene Castle.

The location is ideal for trips to Portugal's capital city Lisbon and also the cosmopolitan town of Cascais where you will find an exciting array of bars,

restaurants and designer shops. Just beyond lies Estoril with its famous casino and nightlife.

The Ritz Carlton Penha Longa Hotel & Golf Resort is a five star oasis set in 545 acres of sheer indulgence. The Ritz Carlton's recent refurbishment programme, renowned service and facilities (which include two championship golf courses) ensure that every guest has a memorable stay.

The 2005 convention business sessions will address the challenges and developments facing the pharmaceutical industry, providing an inspiring exploration into "Navigating in the New World".

The complete programme of business sessions and social events. The convention booklet will be distributed at the end of October 2004.

Wood's world

James Wood, the new president of the British Pharmaceutical Students' Association, talks to Sally Hadden



Meet James Wood, the new president of the British Pharmaceutical Students Association (BPSA). It's a voluntary role, as he's just begun his pre-registration year with the Co-op Pharmacy Group in Huddersfield after graduating from Aston University.

James is clearly committed to the organisation's 5,000 members, speaking passionately about the BPSA's plans for the year. What issues will he be raising and how might these relate to and impact on the pharmacy profession as a whole?

One of James's most immediate concerns is the availability of pre-registration placements for new pharmacy graduates. He explains: "We're very concerned about the perceived lack of pre-reg places in the UK. I think students are finding it much harder to find places for two reasons. Firstly there are increasing numbers of graduates from the new pharmacy schools and secondly not enough employers are offering pre-reg places, which are vital to the future of the profession. We want to campaign for more places and see what we can achieve."

He's worried what the situation might be in five to six years' time when people

might graduate with a pharmacy degree and not be able to get a pre-reg place - even though the UK needs more pharmacists. I think it's important that undergraduates know that they can secure a pre-reg place at the beginning of their course, or at least get some clarity on the issue."

So what steps does James think should be taken to improve the situation? "If the post of a pre-reg tutor was made more attractive to employers, maybe we wouldn't have this problem ... I think we can increase pre-reg placements but the problem does need looking at quite urgently."

Another issue that is relevant to all students (but perhaps more so for pharmacy students who now study the four-year course) is tuition fees, particularly top-up fees and the rising cost of living for students. How does James think this might affect the future of the profession in the UK?

"Top-up fees are a concern for us. Students are already graduating from a four-year pharmacy degree with debts of £15,000 or so. Pharmacy is a fairly expensive course to run and quite competitive, so the costs are going to be high if top-up fees are

Top-up fees are a concern for us. Students are already graduating from a four-year degree with debts of £15,000

The BPSA has its own professional development scheme which we introduced several years ago

introduced. We're concerned that some students will be faced with very high costs to study pharmacy and we're looking at this as an issue this year with a view to formulating a policy about it for the 2005 annual conference."

James thinks that the increase in the number of UK pharmacy schools is a really positive development for the profession. "Obviously the new courses are accredited by the RPSGB so will meet all the required standards, but new schools may look at new ways of delivering their courses and perhaps integrating more clinical practice with theory, which is good."

Which leads us on to another key area of concern for students, namely the content of pharmacy degrees and the amount of clinical practice/hands-on experience they receive during the course. James explains: "Based on what was raised at the annual BPSA conference in March this year, students felt that more applied learning and clinical placements within the MPharm course would improve the learning experience for students. There could also be more specialisation in the course earlier on and perhaps the course as a whole could be reviewed to make it more clinical."

"Now that the course is four years long students feel that the extra, final year may not be doing it justice at the moment and students want the course to be reviewed. A motion was passed at the conference to take these issues to the education committee of the RPSGB."

Is there anything more that employers can do to support undergraduate students and the teaching of pharmacy? James believes so: "Pharmacy schools have teacher practitioners provided by employers and we very much welcome this involvement at an undergraduate level. I'd like to encourage employers to get even more involved – perhaps they could come along and give a talk to members through our area conference network, our annual conference or pre-reg graduate conference and tell them about their company, what's happening in the profession, employment prospects and opportunities, as well as the latest developments – students would find this very useful," says James.

Finally, what about the importance of continuing professional development to the pharmacy profession? James explains: "The BPSA has its own professional development scheme which we introduced several years ago to introduce students to CPD early in their careers. We're improving the way we deliver the scheme this year by giving responsibility to a designated education development officer and moving all the system online – very much like how it will be when students graduate and are working pharmacists. Furthermore, some of our competitions and events are accredited so students can get into good habits before they start their pre-reg year. We're fully behind CPD and actively encourage it."

So what are the BPSA's plans for the next few months? "We're relaunching *Future Pharmacist*, our undergraduate publication, and relaunching our website. We are improving our graduate services by extending the pre-reg conference to a two day event geared towards getting the most out of the pre-reg year and passing the exam."

"Hopefully by the end of the year we'll have our CPD scheme online. We're also assisting the RPSGB in holding a students' day at the British Pharmaceutical Conference. Our new education officer should be in post in September and we're also looking to organise our executive to make sure we can provide representation for students at new pharmacy schools."

"Working more closely with the European Pharmaceutical Students' Association (EPSA) to get the most for our members is something the executive hopes to achieve this year. We also back the Government's early moves to introduce a general smoking ban in public places, so we'll be supporting that."

For further information about the BPSA visit www.bpsa.com

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Mind your own business

Mind Your Own Business is written by pharmacist Dr Terry Maguire. Ten subject areas provide anyone involved in running a pharmacy business with advice on management techniques and style.

Sponsored by AAH Pharmaceuticals and Vantage Pharmacy, *Mind Your Own Business* has been accredited by the College of Pharmacy Practice as an appropriate tool for CPD.

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Ride with pride

The London to Paris Cycle Ride, organised by Rowlands Pharmacy, is now four year's old. C&D's **Phil White** got on his bike ...

It's 4.30am on Saturday. An unholy hour to be up at the weekend. But the man said he wanted to be away from Trafalgar Square by 6am. And if you are foolish enough to volunteer to cycle from London to Paris over the August Bank Holiday weekend then you have to make some small sacrifices.

So by 5.30am we were milling around in the dawn light trying to find our bikes from among those layered against the railings outside the hotel in Great Russell Street, just down the road from the British Museum. Luggage was in the truck, not to be seen again until we arrived in Dieppe. Day sack with passport, waterproof, petroleum jelly (highly recommended at our briefing the night before), spare inner tube, money and other vital necessities in the support van.

The terrace in front of the National Gallery in Trafalgar Square is mercifully quiet at 6am. A good place for the team photo. Your bike looks decidedly dowdy compared to some of the racier models on display. It sports fat tyres, a gel saddle and other non-essentials like mudguards...

Final pep talk from the man. Keep together, steady pace, single file, watch the traffic, listen to instructions from the support team, need to get the 2pm ferry from Newhaven, but don't worry – it's only 70 miles. Too late now to worry about the fact that you never cycled for more than 20 miles at a time in your less than rigorous training schedule. You follow the leader down Whitehall and over Westminster Bridge...

The man is Paul Smith, managing director,

Rowlands Pharmacy. Over the next three days he was to mother us along the side roads to Paris in best sergeant-major style, ably assisted by his quartermaster, Mike Blakeman (projects manager, Rowlands). This is the fourth time they have organised a sponsored cycle ride from London to Paris, and their experience is evident. Each year the number of riders has grown as the word has spread that this is 'good thing' to do. Many of the 37 riders have done it before.

The ride is in aid of the Great Ormond Street Hospital Children's Charity. Since its inception the ride has raised over £70,000 for the Hospital. Mike reckons we will raise over £50,000 this time round.

A fun way to spend the weekend? Not exactly, for most of us, but certainly challenging. The legs do ache a

Below from left: 'Team Novartis' as the ride begins in Trafalgar Square; almost there with the Arc de Triomphe in sight; a rest break en route



bit after six hours of pedalling and your backside gets a bruising... however, the whole experience is made much easier by Mike's formidably efficient administration and help of the ever present support team. While riders have to cover their hotel costs and the ticket home, there is an endless supply of Lucozade Sport and chocolate bars at the rest breaks, and evening meals come courtesy of sponsorship from SSI, Rowlands, Novartis, GSK, G-Pharma, APS, Profile Shopfitting, Reckitts and ADL Healthcare. Oh, and Numark supplied the petroleum jelly!

But back to the road. It's a stop-start experience getting out of London. The bus drivers don't appreciate you in their lane, the motorists are pig ignorant and the roads are lumpy. It seems an age before you pull over into the car park of a (closed) Happy Eater just before crossing the M25 south of Croydon. In a scene frequently repeated over the next two days the chaps line up facing the hedge while the women ... well, they just discretely disappear (maize fields were a popular retreat once we got to France).

Our first real test of stamina is just outside East Grinstead. Turner's Hill is relatively short but unpleasantly steep. Mike Johnson is heard praying for the 'puncture god' and a ride in the support van while he fixes it. At the next rest break a senior moment from a red-faced late arrival: "Will someone get that f...ing front gear shift to f...ing change down!"

It's a small world. On the outskirts of Haywards Heath you cycle past John Ferguson, past secretary and registrar of the Royal Pharmaceutical Society, out walking his dog. He looks a little bemused as you shout his name and pull over. You haven't seen him for several years, but recognition dawns once you take your helmet off.

The weather is just right: warm and cloudy as we thread our way along the lanes through the South Downs past Plumpton. You are allowed to break away from the pack and set your own pace, before being pulled together again on the outskirts of Newhaven. As we wait to board the Seacat, Paul hands out baseball caps. Yours is red and tastefully embossed 'first

time virgin'. After a couple of hours rest it is an effort to get the legs going again once we reach Dieppe for the short ride to the hotel.

Day two

Everyone is well into the routine by day two, buoyed by the fact that they survived day one. Dieppe is a pleasant place and you make a note to go back some day. The Route Vert out of the town has only recently been opened as a cycle route. It follows the track of an old railway line, sandwiched between the DI and the River Bethune. It is flat, straight and fast, and after a while a bit monotonous. A couple of hours later we are back on the road and facing a switchback of long slow hills. Paul keeps everyone together until we are south of Forges les Eaux, when we are let off the leash for an 8km sprint into Songeons. With no one else in sight and not having looked at a map you realise you haven't a clue where you are, other than somewhere in Picardy.

It's a long slow grind up to the outskirts of Beauvais, where Paul announces we are going to practice 'defensive riding' in preparation for Paris on the morrow. Serious stuff! We line up three abreast. Concentrate, keep together, don't let any traffic push in, watch for hand signals from the front. All goes well until the first hill when the formation falls apart as people tackle the slope at their preferred pace. Paul is not happy and knocks us back into formation with a few well-chosen words. It doesn't take long to appreciate the discipline of the defensive phalanx, not that there is much traffic to push through at 2pm on a Sunday.

We arrive at Hotel Relais Mercure well before 3pm. With five hours before dinner the MacDonald's across the road sees a surge of business. The hotel bar runs out of beer glasses, but the barmaid gives as good as she gets. She's English, and married to the hotel chef. It's good to sit outside and chat. Dinner that evening is a relaxing affair. Naughty Nicky from AstraZeneca explains to Curly (Paul), Tiny (Tony) and Gorgeous (George) how she remembers their names. Afterwards in the bar Mike Johnson

produces his song book, while Geoff Willetts and Paul Keeton provide guitar accompaniment. Mike apart, no one is going to win any awards for their singing.

Day three

Paris is in our sights now, so we enjoy the countryside while we can. There are some testing hills and a long climb through Le Tillet, but we are allowed off on our own for the last time once we reach the top. George Thornton is too close behind a tractor and its trailer when it slams on the anchors to avoid an oncoming lorry in a narrow village street. He headbutts the trailer as he goes over the handlebars, but there's no damage.

We regroup before hitting a main road, and it's single file now as there is more traffic and we move into the suburban sprawl north of Paris. The pace is quite fast and the support riders are pushing the slower riders to keep up their speed. We cross the Oise near Bonneville and pull into a garage forecourt for a rest break. Naughty Nicky charms a car wash attendant into hosing down her bike. More defensive riding practice for a few miles, with lots of shouting from the support riders. Lots of drab apartment blocks too. "We got stoned from the top of one of those last year," recalls one rider.

A final rest break round the back of a pre-fab white 'Tex Mex' restaurant. We leave in defensive formation and break into the traffic. It's quite exhilarating and most drivers are quite accommodating. Traffic lights are an interesting challenge. They inevitably change as the peleton is halfway through. Whether the riders at the back keep going or stop is down to a trio of experienced riders in the middle of the pack.

In no time at all we cross the Seine at the Pont de Neuilly and head up Avenue Charles de Gaulle. We sweep around Porte Maillot in fine style and then inch our way up the Avenue de la Grande Armée. The traffic swirling around the Arc de Triomphe is as manic as ever, but the traffic police obligingly block off incoming vehicles to give us some space. It's a grand experience – one a solo cyclist would be suicidal to contemplate – but over so quickly.

Then it's down the Avenue Kleber to the Place de Trocadero. The support vehicles are parked in front of the Palais de Chaillot, which is no mean feat. Bikes are loaded straight away, leaving you free to pose for photos in front of the Eiffel Tower and congratulate your fellow riders on their achievement. See you next year, then? ☺



Above: A well-earned beer for Dave Haydon (Profile), Mike Johnson (Rowlands), and pharmacists George Thornton from Poole and Tony Prendergast from Lowestoft. Top right: the girls from AstraZeneca went through this bonding ritual at each rest break. Bottom right: Jo Skipper (GSK Consumer Health) can't find it! Far right: "Now about these hills..." Paul Smith, left, and Mike Johnson somewhere in France

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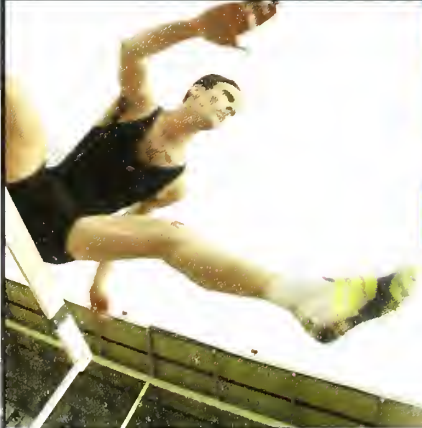
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All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

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AAH Pharmaceuticals has announced two new appointments. **Jessica Bateman** has been named regional sales manager for the Eastern region, covering Romford, Ruislip and Bexhill branches. Ms Bateman has joined from GlaxoSmithKline where she was a national account manager. **Richard Day** is the new business account manager for buying groups. He joins AAH from Chemilines where he was sales and marketing manager.



Jessica Bateman

Generic manufacturer Alpharma Ltd has boosted its sales force with the appointment of four new members to handle major accounts via UniChem and AAH Pharmaceuticals. As key account executives, **Colin Ternent** will cover North East



Richard Day

England and Scotland, **Neil Davis** will deal with the West Midlands, North Wales and North West England, and **Debra Marchant** will be responsible for Eastern and Southern England. In addition, key account manager **Kerry Sheard** has joined the

company from Boehringer Ingelheim.

Katie Tabor has joined Manx Healthcare as national accounts manager. Previously at 3M Health Care Ltd where she worked in UK and European sales and marketing across pharmaceutical, medical, dental and consumer healthcare divisions, Ms Tabor will be responsible for overseeing Manx's new product launches and developing its existing brands.

Ain't no mountain high enough

AAH hospital account manager David Saunders helps pharmacist Rachel Hunt put her best foot forward ahead of her Kilimanjaro challenge



After flying out at the end of this month, Rachel will spend eight days scaling the mountain that lies on the border between Kenya and Tanzania. Her training has included a 510 mile cycle ride to John O'Groats,

Pharmacist Rachel Hunt is scaling the heights to raise money for Diabetes UK – all 19,565ft of Mount Kilimanjaro in fact.

A diabetic since childhood, Rachel has already raised £2,500 in sponsorship including a £300 donation from AAH Hospital Service. As the Leicester General Hospital pharmacist is funding the £1,600 cost of the venture herself, all proceeds will go to the charity.

climbing in the French Alps and hikes in the Peak District.

"Being diabetic makes me determined to show I can do what anyone else can do. I like to think it will encourage others with the condition," she said.

Anyone wishing to support Rachel can send cheques marked for her attention to the Pharmacy Department, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW.

Co-op staff step out for charity

Fifty one members of staff from West Midlands Co-op's pharmacies, food stores and travel agencies raised over £3,000 for charity recently, when they took part in a sponsored walk.

In addition, to give the participants an energy boost, the company donated more than 1,000 bananas to the Juvenile Diabetes Research Foundation which organises the annual Walk to Cure Diabetes event.

Pharmacy locum administrator Heather Broadhurst and her son Ryan, both of whom have diabetes, were among those walking the five-mile course through Sutton Park, Birmingham, on September 12.

The total raised by Co-op staff included sponsorship money and donations totalling £1,000 contributed by several suppliers.

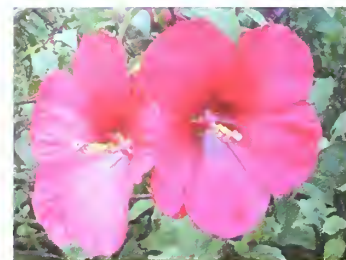


From the left: West Midlands Co-op staff members Heather Broadhurst, Linda Gooderidge, Keith Butler and Emma Whittaker step out for diabetes

Flower power

Virtuous teetotalers who also avoid caffeine may have been worried they were missing out on the recently heralded health benefits of tea and red wine. But now they can relax because scientists in Taiwan have discovered that hibiscus flower extract has a similar effect.

Writing in the *Journal of the Science of Food and Agriculture*, the researchers said they had found that antioxidants contained in the flower helped control cholesterol levels in rats. Lead researcher Chau-Jong Wang said: "Experiments have shown that compounds extracted from red wine and tea reduce cholesterol and lipid build-up in the arteries



of rats. This is the first study to show that hibiscus extract has the same effect."

Although the plant is used as a traditional remedy to treat liver disorders and hypertension in the Far East, hibiscus is an ingredient of many herbal teas in this country, making them healthy as well as low calorie. What more reason for switching from traditional tea is needed?



To celebrate its business partnership with the National Pharmaceutical Association, Alliance & Leicester hosted a golf day for NPA members, staff and board members at the Belfry, Warwickshire earlier this month. Pictured from the left are: NPA board member Dilip Joship, HPA vice-chairman Raj Patel, Alliance & Leicester's Stuart Wilson and NPA finance director Richard Maw

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